Community Align

MEMBER BENEFIT AGREEMENT

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.

If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from Community Health Options ("CHO"). If you have a Medicare supplement policy or major medical policy, this coverage may be more than you need. For information, call the Bureau of Insurance at 1-800-300-5000.

Renewal

Unless your coverage under the Plan from CHO terminates, when you pay your Premium charges, your coverage renews for the period covered by the Premium. Your Plan will automatically terminate on December 31, 2016; however, if you continue to pay your premium and take no action to change your existing policy, your CHO coverage will be renewed for the following calendar year. Your Premium may change at the beginning of the new Plan Year, subject to approval by the Bureau of Insurance. When a change in your Premium occurs, you will receive written notification from us, advising you of the new Premium and the effective date of the change. We will give you at least 60 days' notice of a Premium increase. The change in your Premium will appear in your next bill after the effective date of the change.

10-Day Agreement Review

This *Member Benefit Agreement*, the *Schedule of Benefits*, any Riders, and your *Application* (together, the "Agreement") make up your contract and complete coverage with CHO for Benefits under the Plan. This Agreement replaces any previous health coverage agreement with CHO you may have received.

If you decide not to accept this Agreement, send a signed cancellation form within 10 days of your effective date to:

Community Health Options
Attn: Member Services
Mail Stop 100
P.O. Box 1121
Lewiston, ME 04243

Please check "10-Day Agreement Review Cancellation." We will then refund any Premium charges you have paid us for the Agreement. If you return this Agreement under this provision, we will refund any Premium payment for the Agreement, but CHO reserves the right to recoup costs for any claims incurred during this 10-day period.

Contacting CHO

You may contact CHO Member Services at:

Community Health Options
Attn: Member Services
Mail Stop 100
P.O. Box 1121
Lewiston, ME 04243
Toll-free number: 1-855-624-6463 (TTY/TDD: 711)
Internet: www.healthoptions.org

Non-English speaking Members may also call CHO Member Services at 1-855-624-6463. CHO offers free language interpretation services for people who do not speak English or who have limited English-speaking abilities.

Deaf and hard-of-hearing Members may communicate with CHO Member Services by calling 711. A specially trained operator will help you communicate with CHO Member Services.

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1. INTRODUCTION

A. Introduction to the Agreement

Thank you for choosing Community Health Options (CHO) for your health insurance Plan (the "Plan"). This Agreement is the legal document that defines the relationship between Members and CHO. It describes the Benefits, limitations, conditions, exclusions, and other important information relevant to Members enrolled in the Plan. **Read this Agreement very carefully.**

CHO agrees to cover and arrange for health care services to enrolled Members in accordance with this Agreement. By being an enrolled Member under the Plan, you agree to all the terms of this Agreement.

For specific Benefit details, including any Member Out-of-Pocket Costs, please refer to the *Schedule of Benefits* for the Plan.

Under the Plan, a Member's health care is mainly provided or arranged through CHO's network of Primary Care Providers (PCP), Specialist Providers, and other Providers. The Plan provides Benefits for the health care services described in this Agreement and the *Schedule of Benefits*.

CHO also provides Members with a *Member Handbook*. The *Member Handbook* is not part of this Agreement. Rather, the *Member Handbook* provides Members with helpful information and answers common questions about CHO's services.

You can access your Member materials electronically by downloading them from www.healthoptions.org, electronically by email, or you may request additional paper copies by contacting Member Services. If you have any special cultural needs or require translation services please contact Member Services at 855-624-6463.

B. About Community Health Options

CHO is a Consumer Operated and Oriented Plan ("CO-OP"). The U.S. Centers for Medicare and Medicaid Services has established guidelines for CO-OPs. CHO is a private, nonprofit entity governed by a Board of Directors made up mostly of Members. This representative Board gives Members like you a strong voice in the governance and development of CHO.

Our Mission:

To partner locally with Members, businesses and health professionals to provide affordable, high-quality benefits that promote health and wellbeing.

Our Values:

Community Health Options believes that:

- *Every person is entitled to courtesy and respect.*
- *A trustworthy organization demonstrates honesty, integrity, independence, and consistency in policy and action.*
- *Discipline, focus, courage, and humility enable us to be open to learning from the challenges that confront us.*
- *It is important to embrace change and see positive potential in disruptive innovation.*
- *Spontaneity, balance, thoughtfulness, and curiosity are essential.*

Our Vision:

To be a leader in transforming and improving individual and community health and positively affecting the local economy.

C. How this Agreement Works

1. Generally

   This document explains:

   - Which health care services are Covered Services;
   - What is excluded from coverage under the Agreement;
   - How to obtain Covered Services and how to obtain Prior Approval;
   - Prescription drug benefits (details are in the *Schedule of Benefits*); and
   - Other information about your relationship with CHO.

   Your Out-of-Pocket Costs, that is, costs you must pay, are detailed in the *Schedule of Benefits.*

2. Defined Words

   At the end of this Agreement, you will find a Glossary of defined words used in this Agreement. You will also find elsewhere in this Agreement other defined words. These defined words begin with capital letters. It is important that you understand what these defined words mean.

   When this Agreement uses the words "we," "us," and "our," this means CHO and its designated affiliates. When this Agreement uses the words "you" and "your," this means the Subscriber and all Members and Dependents.

   Unless otherwise clearly noted, lengths of time expressed in terms of days in this Agreement shall mean calendar days.

3. *Schedule of Benefits*

   The *Schedule of Benefits* lists your expected Out-of-Pocket Costs for Benefits and Prescription Drugs covered under the Plan.

4. Plan Providers and the Provider Directory

   The Provider Directory lists the Primary Care Providers (PCPs), Specialists, Hospitals, and other Plan Providers who have contracts with CHO to provide Covered Services to our Members. The regularly updated Provider Directory is available online at https:// www.healthoptions.org/Search-provider. If you do not have online access, you may obtain a printed copy by calling Member Services. Members are encouraged to use Plan Providers. Your Out-of-Pocket Costs are typically lower when you receive Covered Services from a Plan Provider rather than a Non-Plan Provider. CHO's Member Services Associates can answer questions about our Plan Providers.

   Plan Providers have contracts with CHO that can be terminated from time to time, even without notice. If your Plan Provider leaves our network for any reason, we will try to give you at least 60 days' notice. In any case, we will give you as much notice as we can.

To find a new Plan Provider, you may review the Provider Directory or contact Member Services.

In some cases, we may continue to cover the care you receive from your leaving Plan Provider with the same Out-of-Pocket Costs to allow for a smooth transition to a new Plan Provider. If you are undergoing a course of treatment with a Plan Provider who leaves CHO's network, you may have the same Out-of-Pocket Costs with that leaving Plan Provider for at least 90 days from when we notify you that your Plan Provider is leaving. If you are a pregnant Member in the 2nd or 3rd trimester and we notify you that your Plan Provider is leaving, you may have the same Out-of-Pocket Costs, related to that pregnancy, with that leaving Plan Provider through postpartum care.

In the event that you are not able to obtain services from a Plan Provider in your area, you or your Provider should call CHO at 1-855-624-6463 (TTY/TDD: 711) to seek assistance in finding a Plan Provider.

D. Member Rights and Responsibilities

As a Member of the Plan, you have the following rights:

- *You have a right to detailed information about your Plan. This may include information about Benefits and services that are covered under or excluded from the Plan, and all requirements that must be followed for Prior Approval.*
- *You have a right to information about your Out-of-Pocket Costs, and an explanation of your financial responsibility for services provided to you.*
- *You have a right to be treated in a manner that respects your privacy and dignity. We will follow applicable laws and our policies when we handle your information.*
- *You have a right to participate with your Providers in making decisions about your health care.*
- *You have a right to voice complaints or file Appeals with the Plan, and to contact regulatory bodies about the Plan.*
- *You have a right to make recommendations regarding the Plan's Member Rights and Responsibilities policies.*
- *You have a right to receive appropriate assistance from CHO in a prompt, courteous, and responsible manner.*
- *You have a right to be promptly informed of termination or changes in Benefits, services, or Plan Providers.*
- *You have a right to receive an explanation of why a Benefit is denied; the opportunity to Appeal the denial decision; the right to a second level of Appeal with the Plan; and the right to contact the Maine Bureau of Insurance.*
- *You have a right to adequate access to Providers near your home or work within the Plan's service area.*
- *You have a right to receive detailed information about which services require Prior Approval and how to request Prior Approval.*
- *You have a right to have access to a current list of Plan Providers in the Plan's network.*
- *You have a right to a candid discussion of appropriate or medically necessary treatment options for your conditions regardless of cost or benefit coverage.*
- *You have a right to have someone help you follow your responsibilities and exercise your rights under the Plan.*

As a Member of the Plan, you have the following responsibilities:

- *You have a responsibility to provide honest and complete information to the Plan and to your Providers.*
- *You have a responsibility to read and understand the information that you receive about your Plan.*
- *You have a responsibility to know how to properly access coverage and utilize your Plan.*
- *You have a responsibility to understand your health problems and participate in developing treatment goals that you agree to with your Providers.*
- *You have a responsibility to follow plans and instructions for care that you have agreed to with your Provider.*
- *You have a responsibility to present your Member identification card before you receive care or, in emergency situations, after you receive care.*
- *You have a responsibility to pay your applicable Deductible, Coinsurance and Copayment amounts.*
- *You have a responsibility to express your opinions, concerns or complaints in a constructive way to the Plan or to your Provider.*
- *You have a responsibility to timely inform the Plan of any changes in family size, address, phone number, or Member eligibility status.*
- *You have a responsibility to make Premium payments on time, even if you have made arrangements with a third party to make such payments.*
- *You have a responsibility to notify the Plan if you have any other insurance coverage.*

2. HOW YOUR PLAN WORKS

A. Care Management and Medical Management/Utilization Review

CHO is committed to ensuring Members receive high quality, medically appropriate care. An important part of the Plan is our medical management and care management services. Our medical management team performs utilization review of health services to ensure they are Medically Necessary, evidence-based and delivered in the most effective health care setting.

If you are hospitalized, have complex or serious health conditions, or are transitioning from one health care facility to another, our team will review your situation and determine whether you may benefit from care management services. These services are provided to you at no additional Out-of-Pocket Cost.

When you are hospitalized, our Medical Management team will monitor your care to ensure you receive high quality services that are most appropriate for your condition. We will also work closely with the Hospital staff to help plan your discharge from the Hospital to help make it a smooth transition and provide you with access to the health care services that are most appropriate for your condition. Our care managers work closely with your Primary Care Provider and local care management teams to coordinate your care. Our care managers can coordinate your Specialist appointments and help you obtain prescribed care such as Durable Medical Equipment, medical supplies, or Prescription medications.

CHO applies objective and evidence-based criteria and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services. Under extraordinary circumstances that involve complex care or care management services the Plan may provide Benefits for services that are not listed in the "Covered Services" section 4.B. The Plan may also continue Covered Services beyond the contractual Benefit limit of this Agreement. These decisions are made on an individual basis and a decision to provide alternate services or continue Benefits is not precedent setting, and it does not obligate us to continue to provide those Benefits to you or any other Member in the future. We reserve the right, at any time, to change or stop providing alternate service Benefits or extended Benefits. Should we decide to change or stop your alternate services, we will notify you of that decision in writing.

Members, their caregivers, Providers and local care managers can refer Members for care management services by contacting Member Services at 1-855-624-6463.

1. <u>Chronic Condition Support (Disease Management)</u>

   We proactively identify Members with, or at risk for, certain chronic medical conditions. Our chronic condition program supports the Provider-patient relationship and plan of care, emphasizes the prevention of exacerbation and complications using cost-effective, evidence-based practice guidelines and self-management strategies. We contact eligible Members through mail and phone calls.

   Members, their caregivers, Providers and local care managers can refer Members for chronic condition support by contacting Member Services at 1-855-624-6463. Members can opt out of our chronic condition program at any time by calling Member Services.

2. Healthy Options: Support of Healthy Living

CHO's Healthy Options program offers wellness and health promotion programs designed to provide support for individuals based on their preferred style of engagement. We offer online access to health information and self-management tools as well as a team of Health Advocates who provide individual health coaching via phone AT 1-800-571-8350 at no Out-Of-Pocket cost. For additional information about our Healthy Options program visit www.healthoptions.org or call Member Services at 1-855-624-6463.

B. Preventive Services

1. Generally

CHO covers Preventive services and tests to identify diseases or medical conditions prior to any signs or symptoms being present. Under the terms of the Plan, Services defined in federal law that meet the criteria of Preventive Care are covered at no Out-of-Pocket Costs to you when you receive these services from a Plan Provider. You will be responsible for paying applicable cost-sharing for Preventive Services that are not defined in federal law, Diagnostic Services and other services that do not qualify as Preventive.

If a Provider recommends a service or test based on an office visit (including a Preventive exam), your symptoms, or a prior diagnosis or treatment, the service or test will be considered diagnostic and will ***not be eligible*** for coverage as a Preventive Service.

2. Preventive Services that are covered with no Out-of-Pocket Costs

Services will be covered as Preventive with no Out-of-Pocket Costs to you if:

a. The care or service:
   - received a rating of "A" or "B" from the United States Preventive Services Task Force (USPSTF) (available at www.uspreventiveservicestaskforce.org);
   - is an immunization recommended for a given age group by the Advisory Committee on Immunizations Practices of the Centers for Disease Control and Prevention;
   - is in the comprehensive guidelines for preventive care and screenings for infants, children, adolescents and women supported by the Health Resources and Services Administration;

b. Screenings and other services are generally covered as Preventive Care for adults and children with no current signs or symptoms of a medical condition. Members who have current symptoms of a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the Diagnostic Services benefit and subject to the coinsurance and/or deductible applicable to your plan; and

c. The Provider bills the care or service with the CPT codes and diagnosis codes properly listed on the appropriate claim form. The preventive diagnosis code should be in the primary position.

Preventive services that are available at no Out-of-Pocket cost to you include:

- **Abdominal aortic aneurysm screening** through ultrasound; one time for men aged 65 to 75 who have ever smoked.
- **Alcohol and drug use assessments** for adolescents.
- **Alcohol misuse counseling** through behavioral counseling interventions in the primary care setting. Counseling for people engaged in risky or hazardous drinking with brief interventions to reduce alcohol misuse.
- **Alcohol misuse screening** for adults age 18 years or older for alcohol misuse and risky or hazardous drinking. Must be performed by a clinician for persons engaged in risky or hazardous drinking.
- **Anemia screening** for iron deficiency anemia in asymptomatic pregnant women.
- **Aspirin to prevent cardiovascular disease** for men ages 45 to 79 and women ages 55 to 79, when the potential benefit due to myocardial infarction outweighs the potential harm due to an increase in gastrointestinal hemorrhage.
- **Autism screening** through identification and evaluation of children with autism spectrum disorders.
- **Bacteriuria (urinary tract) screening** for asymptomatic bacteriuria with urine culture in pregnant women.
- **Behavioral assessments** for infants, children and adolescents.
- **Blood pressure screening** for adults and children.
- **BRCA genetic counseling/testing** through genetic counseling and BRCA testing for women who screen positive during BRCA screening.
- **BRCA risk assessment** for women who have family with breast, ovarian, tubal or peritoneal cancer.
- **Breast cancer chemoprevention counseling** and shared, informed decision making with women who are at increased risk for breast cancer.
- **Breast cancer preventive medications**, such as tamoxifen or raloxifene, prescribed by clinicians for women who are at increased risk for breast cancer.
- **Breast cancer screening mammography**, with or without clinical breast exam, every 1 to 2 years for women age 40 and over.
- **Breastfeeding interventions/counseling** during pregnancy and after birth to promote and support breastfeeding.
- **Breastfeeding supplies** (equipment rental), support and counseling.
- **Cervical cancer screening** for women with cytology (pap smear) once every 3 years, HPV test once every 3 years for women age 30 to 65.
- **Cervical dysplasia screening** for sexually active adolescent females.
- **Chlamydia screening** for sexually active women age 24 years or younger and in older women who are at increased risk of infection through nucleic acid amplification tests in the form of a urine culture or vaginal swab.
- **Cholesterol abnormalities screening** for lipid disorders (blood test – lipid panel), including for adults at increased risk for coronary heart disease.
- **Colorectal cancer screening** for adults between 50 and 75. Colonoscopy once every 10 years; sigmoidoscopy once every 5 years; fecal testing once annually. If polyps are found and removed during a preventive screening colonoscopy, the screening and polyp removal will remain no cost to you.

- **Contraception** approved by the FDA to prevent pregnancy, including related consultations, examinations, procedures, and medical services provided on an Outpatient basis. Coverage includes sterilization procedures, and patient education and counseling. Covered prescription contraceptives, according to the formulary, will be covered at no member cost-sharing when prescribed by a Plan Provider regardless of the formulary tier when the prescription indicates a brand requirement.
- **Depression screening** for adults and children. Clinician screening of adults when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up. Primary care screening of adolescents for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy, and follow-up.
- **Developmental screening** for children under 3 years of age.
- **Diabetes screening** for type 2 diabetes in asymptomatic adults with ongoing high blood pressure greater than 135/80 mm hg through fasting plasma glucose, 2-hour postload plasma glucose, and hemoglobin A_{1c}.
- **Diet and physical activity counseling** through intensive behavioral counseling interventions for adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to promote a healthful diet and physical activity for CVD prevention.
- **Dyslipidemia screening** for children between at 1 and 21 at higher risk of lipid disorders.
- **Flouride Chemoprevention supplements** for children without fluoride in their water source.
- **Folic acid supplementation**, daily supplement containing 0.4 to 0.8 mg of folic acid, for all women planning or capable of pregnancy.
- **Gestational diabetes mellitus screening** by oral glucose tolerance test for asymptomatic pregnant women after 24 weeks of gestation.
- **Gonorrhea screening** by nucleic acid amplification tests in the form of a urine culture or vaginal swab for sexually active women age 24 years or younger and in older women who are at increased risk for infection.
- **Hearing loss screening** in all newborn infants using validated 1-step or 2-step screening protocol.
- **Height, weight and body mass index measurements recorded** throughout childhood in primary care setting through age 21.
- **Hematocrit or hemoglobin screening** for iron deficiency and iron-deficiency anemia in infants and young children.
- **Hemoglobinopathies** for sickle cell disease in newborns through thin-layer isoelectric focusing or high performance liquid chromatography.
- **Hepatitis B screening** for all people at high risk for infection through a blood test.
- **Hepatitis c virus infection screening** by blood test for people at high risk for infection or people born between 1945 and 1965
- **HIV screening** by blood test for anyone at increased risk.
- **HIV counseling** for sexually active women.
- **Hypothyroidism screening** through blood test (TSH and/or T_4) for congenital hypothyroidism in newborns.
- **Immunization vaccines** recommended per section 4.B.60 for adults and children.
- **Interpersonal and domestic violence counseling** for women in the primary care setting.

- **Intimate partner violence screening** for women of childbearing age for intimate partner violence, such as domestic violence.
- **Iron supplementation** in children ages 6 to 12 months who are at increased risk and average risk for iron deficiency anemia.
- **Lead screening** for children at the risk of exposure.
- **Lung cancer screening** with low-dose computed tomography in adults ages 55 to 80 who have smoked within the last 15 years and have a 30 pack-year smoking history. Screening should be discontinued once the individual has not smoked for 15 years or a health problem develops that significantly limits life expectancy or the ability or willingness to have curative lung surgery.
- **Obesity counseling/interventions** through medical nutrition therapy for children age 6 to 18 years old. Periodic obesity assessments and interventions.
- **Obesity management** for adults with a body mass of 30 kg/m^2 or higher through intensive, multicomponent behavioral interventions. Weight loss programs that have 12 to 26 session in a year and that include a variety of activities and strategies to help people lose weight.
- **Obesity screening** through calculation of BMI for adults and children over 6.
- **Obesity screening and counseling**.
- **Ocular prophylactic medication** for all newborns.
- **Oral Health risk assessment** for young children. Ages 0 to 11 months, 1 to 4 years, 5 to 10 years.
- **Osteoporosis screening** by dual-energy x-ray absorption of the hip and lumbar spine in women age 65 years and older and in younger women at higher risk.
- **Phenylketonuria screening** in newborns through Guthrie Bacterial Inhibition Assay, automated fluorometric assay, or tandem mass spectrometry.
- **Preeclampsia prevention** through use of low-dose aspirin as preventive medication after 12 weeks of gestation in women who are at high-risk for preeclampsia.
- **Rh (D) incompatibility screening** (initial and additional) by blood test for pregnant women during the first visit for pregnancy-related care and for all unsensitized rh (D)-negative women at 24 to 28 weeks' gestation, unless biological father is known to be rh (D)-negative.
- **Sexually transmitted infections counseling** for sexually active adolescents and for adults who are at increased risk for sexually transmitted infections. Counseling focuses on helping a person change behaviors to reduce risk, through one-on-one conversations, videos, written materials, and telephone support.
- **Sexually transmitted infections screening** for sexually active women and adolescents at higher risk of STIs.
- **Skin cancer behavioral counseling** for all people who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
- **Syphilis screening** for all people at increased risk using nontreponemal tests (VDRL or RPR) and confirmatory tests (FTA-ABS or TPPA).
- **Tobacco use screening, counseling and interventions**, including FDA-approved tobacco cessation medications (both prescription and over-the-counter medications), limited to two 90-day treatment regimens for prescription medications per Calendar Year; tobacco cessation programs, follow-up education, counseling, and completion of CHO-approved smoking cessation program.

- **Tuberculin testing** for children at higher risk.
- **Vision screening** for all children.
- **Visual acuity screening** for children at least once between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors through a visual acuity test, stereoacuity test, cover-uncover test, hirschberg light reflex test, autorefraction, photoscreening.
- **Well-woman visits** for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception care and many services necessary for prenatal care.

For additional information about coverage, exclusions and limitations, and other preventive services, please see the Covered Services section 4.B below or call Member Services.

C. Reviews of Hospital Admissions

1. Generally

   With the exception of Medical Emergency and maternity Hospital admissions, CHO requires that we be notified before you are admitted to the Hospital. For elective admissions with pre-service authorizations on file, your Provider must also notify us within 48 hours of your actual admission date.

   For Medical Emergency and maternity Hospital admissions, you, your Designee, or your Provider must notify us within 48 hours after admission. We will conduct a review of your admission.

   Should you be admitted due to a Medical Emergency to a Hospital that is a Non-Plan Provider, your Out-of-Pocket Costs will be at the Plan Provider level only until your condition reasonably allows you to be transferred to a Hospital that is a Plan Provider. If you decide to stay beyond the time that you can be transferred to a Plan Provider Hospital, the rest of your Inpatient Stay Out-of-Pocket Costs will be at the Non-Plan Provider level.

2. While You Are in the Hospital

   We will periodically review your Inpatient Stay at the Hospital while you are still in the Hospital. We want to ensure that you are receiving a proper level of care in the proper setting.

   End of Benefits

   When we decide that the Plan will no longer cover your Inpatient Stay at the Hospital, we will notify you and your Provider. We will explain the reason(s) behind our decision and when the Plan will no longer provide Benefits. Any Inpatient Stay beyond this time will not be covered by the Plan and you may be personally responsible for any costs relating to the continued Inpatient Stay.

3. Observation Status

   If you have not been admitted to a Hospital but are registered by the Hospital for observation, this means that the Hospital staff is monitoring your health status while awaiting test results. Based on that monitoring and testing you may be admitted as an

Inpatient or discharged home for follow up with your personal Provider as an Outpatient. If you are registered for observation, your cost-sharing will be considered "Other Services." If you are not admitted to the hospital, you may incur Emergency Room cost-sharing in addition to the cost-sharing associated with observation status.

D. Getting Care from Your Primary Care Provider

1. Choosing Your PCP

Having a strong relationship with a Primary Care Provider (PCP) whom you trust is important to maintaining and improving your health. An important step after you have enrolled in the Plan is to choose a PCP. When you enroll, you have the opportunity to identify PCPs for yourself and each of your Dependents. If you do not choose a PCP when you first begin coverage with CHO, or if the PCP you select is not available, we will assign a PCP for you. You have the option to change your PCP at any time. To change your PCP, please call Member Services at 1-855-624-6463 or visit https://www.healthoptions.org/registration. If your PCP stops being a Plan Provider, we will try to give you 60 days' advance notice. In any case, we will give you as much notice as we can. You will then need to select a new PCP who is available or we will assign one for you.

It is important for you to get to know your PCP soon after your coverage first begins or whenever you choose or are assigned a new PCP. You should have your medical records sent to your new PCP.

Except where indicated in this Agreement, a Referral from your PCP is not required for visits to Specialists and specialty Providers, but we encourage you to notify your PCP so that your PCP can help coordinate your care.

Please note that your PCP may recommend a Specialist or other Provider who is not in the CHO Network. Please visit www.healthoptions.org or call Member Services at 1-855-624-6463 (TTY/TDD: 711) if you have questions about the Network status of Providers recommended by your PCP or if you would like to nominate a Provider to be considered for inclusion in the Community Health Options Network.

Certain preventive services as defined in Federal law are covered with no Out-of-Pocket Cost to you when provided by a Plan Provider. Please see the Preventive Services section 2.B and section 4.B.60 below or contact Member Services for more information.

2. Obtaining Care from Your PCP

When you need care, we recommend that you first contact your PCP. Your PCP can help coordinate the care you need. In the event of a Medical Emergency, you should obtain needed care immediately. Your PCP's office can tell you how they cover patient needs outside of business hours.

E. Going to the Hospital or a Specialist

This Plan covers Hospital and Specialist services. The Plan does not require Referrals except where indicated in this Agreement, but in some cases, Prior Approval by CHO is required. Please refer to section 2.H for more information.

1. If You Have a Medical Emergency

If you need Medical Emergency services, you should go immediately to the nearest emergency department or call 9-1-1 or another local emergency number. You do not need Prior Approval for Medical Emergency services.

Medical Emergencies include, but are not limited to:

- Heart attack;
- Stroke;
- Severe trauma;
- Shock;
- Loss of consciousness;
- Seizures; and
- Convulsions.

If you are hospitalized, you or your Designee must call your PCP and CHO within 48 hours after receiving Medical Emergency services. If you or your Designee cannot call within 48 hours, then we should be called as soon as possible. If your Medical Emergency services Provider tells your PCP and CHO that you have been hospitalized, you do not need to call your PCP and CHO. Your PCP will arrange for any follow-up care you may need.

Your emergency department Out-of-Pocket Costs are listed on the *Schedule of Benefits*. If you are admitted to the Hospital from the emergency department, your Out-of-Pocket Costs for the emergency department visit as outlined in the *Schedule of Benefits* will be waived.

F. Prescription Drugs

1. Formulary

CHO reviews and selects drugs for the formulary that will be safe, effective, and affordable. These formulary selections are based on their therapeutic value, side effects, and cost compared to similar medications. CHO regularly evaluates the formulary to ensure it is up-to-date. Updates to the formulary will be posted to the CHO website within 72 hours of the change.

Determination of coverage is made by CHO. Your formulary is evaluated on an ongoing basis, and could change. CHO does not send separate notices if a brand-name drug becomes available as a generic drug. The pharmacist usually tells you this information when you fill your next prescription. If you have more questions about the formulary or your Out-of-Pocket Costs, please contact Member Services at 1-855-624-6463 (TTY/TDD: 711). For access to the formulary, please visit our website at https://www.healthoptions.org/Documents/Maine-Comple-formulary.

CHO has a process for allowing exceptions to our formulary. To obtain coverage for a drug not on our formulary, you, your Designee, or the prescribing Provider must submit a request to CHO with a clinical rationale for the exception. We will make a decision within 48 hours, or in exigent circumstances, within 24 hours. Exigent circumstances exist when you are suffering from a health condition that may seriously jeopardize your

life, health, or ability to regain maximum function, or when you are undergoing a current course of treatment using a non-formulary drug.

In the case of exigent circumstances, if the request for coverage is approved, coverage for the drug will be available for the duration of the exigency. If the request for coverage is approved, the drug will be covered as a Tier 3 drug (cost-sharing will apply as listed in the *Schedule of Benefits*), and the prescription will be considered a Covered Service.

2. Prescription synchronization

   Per Maine law, prorated daily cost-sharing rates apply to prescriptions dispensed by an In-Network pharmacist for less than a 30-day supply if the prescriber or pharmacist determines that filling or refilling a prescription for less than a 30-day supply is in the best interest of the Member and the Member requests or agrees to less than a 30-day supply in order to synchronize the refilling of that prescription with the patient's other prescriptions. The requirement does not apply to prescriptions for (a) solid oral doses of antibiotics; or (b) solid oral doses that are dispensed in their original container as indicated in the federal Food and Drug Administration Prescribing Information or are customarily dispensed in their original packaging to assist a patient with compliance.

3. 90-Day Program

   CHO offers a 90-day supply program that gives you the convenience of getting up to a 90-day supply of most drugs at participating retail pharmacies. If you get a prescription filled on a regular, recurring basis, talk to your Provider about writing a prescription for a 90-day supply. A list of pharmacies participating in the 90-Day Program can be found at www.healthoptions.org.

4. Dispense as Written

   If you and your Provider determine that a brand name prescription is more appropriate than the generic, and the brand name is not included on our formulary, your Provider may check the Dispense as Written (DAW) box on the prescription. If the brand-name drug is chosen when the equivalent generic drug is available on our formulary, the Out-of-Pocket Cost for the filled prescription will be the amount listed on your *Schedule of Benefits* for non-preferred brand plus the difference between the actual cost of the generic drug and the brand-name drug.

   The Out-of-Pocket Cost for the non-preferred brand plus the additional cost difference are not considered eligible expenses and therefore will not accumulate toward your Out-of-Pocket Costs.

   If you have an intolerance for a generic drug and require the brand-name drug, then you can submit an Appeal. In this case, your Provider must also file an appropriate report with the FDA regarding the issues you are having with the generic drug. If the request for coverage is approved, the drug will be covered as a Tier 3 drug (cost-sharing will apply as listed in the *Schedule of Benefits*, and the prescription will be considered a Covered Service).

5. Mail Order

   You may obtain a 90-day supply of covered maintenance drugs and certain covered controlled substances by mail. The use of mail order is recommended for drugs used to treat chronic, long-term conditions, rather than drugs for short-term treatment. Contact Member Services for more information on CHO's mail order program.

6. Continuing Prescriptions from a Prior Insurance Carrier

   If you have received Prior Approval for a prescription drug from your former insurance carrier, and that prescription drug also requires Prior Approval from CHO, we will honor the prior authorization to ensure you can obtain your prescription without interruption while we conduct a review. You have the right to request a review with your Provider. If your Provider participates in the review and requests that your prior approval be continued, we will honor the prior carrier's approval while we perform a review, not to exceed 6 months. Continued approval will be determined based on the decision from our review.

7. Prescription Refills

   The Plan only provides Benefits for prescription refills when you have taken 70% of the medication from a retail pharmacy or 70% from mail order, based on the dosage and day supply prescribed by your Provider. The Plan does not provide Benefits for refills exceeding the number specified by the Provider or for refills dispensed after one year from the date of original prescription order.

8. Exclusions

   The Plan does not provide Benefits for certain drugs or appliances as listed in section 5 (Exclusions from Benefits) unless otherwise stated.

G. CHO Medical Policy

CHO has a *Medical Policy* to help CHO determine if services are Medically Necessary. We will utilize our *Medical Policy* only for services that are Covered Services.

CHO periodically reviews the value and effectiveness of new medical technologies and treatments. Those technologies and treatments that are deemed appropriate will be included as part of our benefit structure.

H. Prior Approval

1. Introduction

   Some Covered Services require Prior Approval from CHO before we will pay Benefits. The Prior Approval program helps us ensure that:

   - You are eligible to receive services at the time of the request;
   - The requested service is a Covered Service;
   - The services you receive are Medically Necessary;
   - You receive the appropriate level of care in the appropriate setting;
   - Information is shared with your Providers so that your care can be coordinated; and

- We pay the correct amount of Benefits.

If Prior Approval is granted for a service, Benefits will be paid as described in the *Schedule of Benefits* (unless there is a reason to deny Benefits).

If we grant Prior Approval for a Covered Service that is based on information given to us that is fraudulent or materially incorrect, we may retroactively deny Prior Approval for that Covered Service.

Sometimes, your Prior Approval request will be medically reviewed by a Physician (or a qualified clinician for mental health or substance abuse services or a pharmacist for drugs).

We do not pay or give incentives to our employees or contracted Providers to improperly deny or withhold Benefits. CHO staff involved in Prior Approval decisions must also sign a conflict of interest statement each year.

a. Prior Approval for Urgent Care

We will make a decision on a Prior Approval request for Urgent Care as soon as possible taking into account the medical situation, but always within 48 hours after receiving all necessary information to review the request.

If the request is missing information, this may delay our decision. We will let you or your representative know within 24 hours after receiving the request what information we need to make the decision. We will give you or your representative a reasonable amount of time to provide the needed information, which will be at least 48 hours. We will make the decision as soon as possible, but in no case later than 48 hours after the earlier of (1) our receipt of all of the necessary information, or (2) the request for additional information if additional information is not received.

b. Prior Approval for Ongoing Course of Treatment Involving a Medical Necessity Question

We will make a decision on a Prior Approval request for an ongoing course of treatment involving a Medical Necessity question within 24 hours after receiving the request, provided that the request is made at least 24 hours before the approved treatment time period expires. We will inform you or your representative within 24 hours after receiving the request if we need more information to make the decision. Written notification will include the number of extended days or next review date, the total number of days or services approved, and the date of admission or initiation of services. We will not approve a request unless we receive all needed information. Ongoing care will be continued without liability to you until you are notified of the coverage determination.

c. All Other Prior Approval Requests

We will make a decision on requests for Prior Approval not involving Urgent Care or an ongoing course of treatment involving a Medical Necessity question within two working days of receiving all the information necessary to review the request.

If the request is missing information, this may delay our decision. We will let you or your representative and your Provider know within two working days if we require more

information after receiving the request. If we determine that outside consultation is necessary, we will notify you or your representative within two working days.

2. Services Needing Prior Approval or Notification

Some services require Prior Approval before Benefits will be provided by the Plan. Some services require that we be notified that you have received services. If you have any questions or need assistance to determine which services require Prior Approval or notification, please visit www.healthoptions.org or call Member Services at 1-855-624-6463 (TTY/TDD: 711).

If you fail to obtain Prior Approval for a service needing Prior Approval, or if you fail to submit prior notification for a service that requires notification, you may not receive Benefits for that service and you may be responsible for the full cost of the service.

Services that require notification (see section 6 for more information about payment of claims)

The facility must notify CHO Utilization Management in the following manner:

- Call PRIOR TO ADMISSION for Long Term Acute Care (LTAC)
- Call PRIOR TO ADMISSION for Inpatient Pediatric Feeding Program – PRIOR AUTHORIZATION REQUIRED
- Call UPON ADMISSION – Acute Inpatient; Acute Rehabilitation; Home Health; Skilled Nursing Facilities
- Call PRIOR TO TRANSFER from one Acute Care Hospital to another Acute Care Hospital
- NOTIFICATION by the PROVIDER RENDERING OB SERVICES is requested for Inpatient OB Care (pregnancies) UPON ADMISSION

Types of services that generally require Prior Approval. Detail on specific services requiring Prior Approval is available at www.healthoptions.org/Health-Care-Professionals/Documents-Forms

- All Out-of-Network Facilities
- Ambulance/Air Transportation
- Cardiac Surgery/Cardiovasular
- Chemotherapy
- Dental and Orthognathic Related Services
- Diagnostic Imaging
- Durable Medical Equipment (DME), Orthotics, Prosthetics; Oxygen Equipment and Contents
- Ear, Nose and Throat services
- Gastroenterology and General Surgery
- Genetic Testing
- Genitourinary
- Hearing Aids or Repairs
- High cost infusions/injectables
- Home Infusion Services
- Hyperthermia Treatment

- Long Term Acute Care (LTAC) facilities
- Neurosurgery
- Nutritional Products/Services
- Ophthalmology
- Orthopedics
- Out-of-Network Skilled Nursing Facilities, Long Term Acute Care, Acute Inpatient Rehab, Home Health Agencies
- Outpatient Services
- Pain Management-Spinal Pain
- Plastic, Reconstructive and/or Cosmetic Procedures
- Potentially Experimental or Investigational Services
- Radiation Oncology
- Transplant related services including initial consult and evaluations
- Wound Care Clinic
- Wound Care Products and Procedure

3. Seeking Prior Approval

If you use a Plan Provider, he or she is responsible for obtaining Prior Approval for you. If your Plan Provider fails to acquire Prior Approval for you, you will not be financially responsible for this failure.

If you use a Non-Plan Provider or your services are ordered by a Non-Plan Provider, you (or your Designee) are responsible for obtaining Prior Approval for any services requiring Prior Approval. To seek Prior Approval, please contact CHO at 1-855-624-6463 (TTY/TDD: 711).

If you seek services from a Non-Plan Provider and fail to obtain Prior Approval for a service needing Prior Approval, or you fail to provide notification as required, you may not receive Benefits for that service and you may be responsible for the full cost of the service.

Services for Medical Emergencies do not need Prior Approval. In the event of an admission due to a Medical Emergency, you (or your Designee) must contact CHO within 48 hours after you are admitted or as soon as reasonably possible. However, if your Medical Emergency services Provider tells your PCP and CHO that you have been hospitalized, you do not need to call your PCP and CHO.

4. Prior Approval Decisions

We will notify you or your representative, and your Provider, of our Prior Approval decisions. Our Prior Approval decisions will discuss whether the requested service is Medically Necessary and is a Covered Service. A denial of coverage based on Medical Necessity (sometimes referred to as an Adverse Health Care Treatment Decision) are initially communicated verbally to the Provider, then followed up in writing to you or your representative and the Provider. The written notification cites the reason(s) why the decision was made and includes information about the Appeals process and the right to request in writing copies of any clinical criteria applied in a denial of coverage decision.

Additionally, Members will receive written notification of any denial of coverage that is based on non-covered Benefits or Benefit limits that have been reached (known as an Adverse Benefit Determination). The written notification cites the reason(s) why the decision was made and includes information about the Appeals process and the right to request in writing copies of any criteria applied in a denial of coverage decision. Adverse Benefit Determinations also include Claim Denials and are described in section 6.A.

For more information on the process for appealing Adverse Health Care Treatment Decisions or Adverse Benefit Determinations, please see section 8, Appeals and Complaints.

I. Pediatric Dental Coverage

This Plan provides Benefits for pediatric dental services through Delta Dental Plan of Maine, Inc. Dental benefits are only available to persons who are 18 years of age or less as of the effective date of coverage, except as provided in this Agreement. An eligible Member may choose to go to any dentist and receive some level of Benefits, but Members receive the best value when visiting a Delta Dental PPO Dentist. For additional information, please consult the Covered Services section of this Member Benefit Agreement for full details. See Appendix A for full details of this coverage.

J. Chronic Illness Support Program

If you have been diagnosed with hypertension (high blood pressure), diabetes, asthma, chronic obstructive pulmonary/lung disease (COPD or emphysema), or coronary artery disease (CAD), you can benefit from our *Chronic Illness Support Program.* We included these five conditions in this program because medical experts agree there is strong evidence that these enhanced covered services work well.

Chronic illness means that you will always have the diagnosis, even if you do not have any symptoms. Chronic illnesses are different from illnesses that are expected to resolve or go away. For example, gestational diabetes is not included in this program because it usually goes away when the baby is born and is not a chronic illness.

This program provides reduced Out-of-Pocket Costs (Copayments, Coinsurance, and Deductibles) when performed by a Plan Provider. Prescription drugs listed on our formulary as Tier 1 or Tier 2 will also have reduced Out-of-Pocket Costs. Tier 3 and specialty drugs are not included as part of this program. Speak with your Provider about whether or not alternatives to Tier 3 drugs are available. The *Chronic Illness Support Program* includes Medically Necessary services for routine treatment of the above five conditions. The program includes:

1. <u>Diabetes</u>

   Expanded pharmacy coverage is limited to $0 Out-of-Pocket Cost for generic medications and a reduction in Out-of-Pocket Cost for preferred brand medications as outlined below. On plans that apply a Deductible and Coinsurance for preferred brand medications, the Deductible is waived and the Coinsurance is reduced by half.

   All specific medication used to treat diabetes, hypertension, and hyperlipidemia that are on our formulary and are approved by the federal Food and Drug Administration (FDA)

are covered under this reduced Out-of-Pocket Cost benefit. Antibiotics and steroids are among those drugs that are not part of the reduced Out-of-Pocket Cost benefit.

The following services related to diabetes are covered with $0 Out-of-Pocket Cost when performed by a Plan Provider (unless otherwise noted):

- Office visits to a Primary Care Provider for routine management of diabetes
- Endocrinology consultation and management of diabetes
- Podiatry consultation for routine diabetic foot care
- Nutritional counseling, diabetes education and behavioral modification counseling
- Diabetic eye exam will be covered once a year
- One glucometer each year
- Glucose test strips listed on formulary: up to 50 every 30 days or 150 every 90 days at $0 Out-of-Pocket Cost. Requests for additional costs strips will be considered based on Medical Necessity.
- Laboratory services linked to a diabetes primary diagnosis code

Please note, if you have complications from Diabetes and use an emergency department, have a Hospital stay, or get treated for heart or kidney problems, the usual and customary Plan costs for these services apply, and will be subject to standard Out-of-Pocket Costs as outlined in your *Schedule of Benefits*.

Insulin pumps and supplies are considered Durable Medical Equipment (DME) and are covered according to the *Schedule of Benefits*. DME over $400 require Prior Approval.

2. Hypertension

Expanded pharmacy coverage is limited to $0 Out-of-Pocket Cost for generic medications and a reduction in Out-of-Pocket Cost for preferred brand medications as outlined below. If the Plan applies a Deductible and Coinsurance for preferred brand medications, the Deductible is waived and the Coinsurance is reduced by half.

All specific medications used to treat hypertension that are on our formulary and are approved by the FDA for treatment are covered under this reduced Out-of-Pocket Cost benefit. All specific medications to treat hyperlipidemia that are on our formulary and are approved by the FDA for that treatment are covered under this reduced Out-of-Pocket Cost benefit.

The following services related to hypertension are covered with $0 Out-of-Pocket Cost when performed by a Plan Provider:

- Office visits to a Primary Care Provider for routine management of hypertension
- Immunizations: Influenza, pneumococcal
- Office visits for consultation and management specifically for a diagnosis of hypertension with cardiology or nephrology Specialists
- Laboratory services that are linked to a hypertension primary diagnosis code

Please note, if you have complications from hypertension and use an emergency department, have a Hospital stay, or get treatment for heart and kidney disease services will be subject to standard Out-of-Pocket Costs as outlined in your *Schedule of Benefits*.

3. Asthma/Chronic Obstructive Lung Disease (COPD)/Emphysema

Expanded pharmacy coverage is limited to $0 Out-of-Pocket Cost for generic medications and a reduction in Out-of-Pocket Cost for preferred brand medications as outlined below. If the Plan applies a Deductible and Coinsurance for preferred brand medications, the Deductible is waived and the Coinsurance is reduced by half.

Medications that are on the formulary and are approved by the FDA for treatment of asthma & COPD are covered under this reduced Out-of-Pocket Cost benefit.

The following services related to asthma/COPD/emphysema are covered with $0 Out-of-Pocket Cost when performed by a Plan Provider:

- Office visits to a Primary Care Provider for routine management of asthma/COPD/emphysema
- Immunotherapy to reduce impact and severity of allergic reactions
- Immunizations: influenza, pneumococcal
- Inhaler adjuncts (e.g., spacer)
- Office visits with pulmonologist for consultation and management when associated with a diagnosis of asthma, COPD or emphysema
- Diagnostic testing: pulmonary function test once per year, home oxygen therapy assessment
- Asthma education: allergens/triggers, asthma action plan and behavioral modification counseling
- Pulmonary rehabilitation and ongoing exercise program for moderate to severe COPD. This requires Prior Approval
- Asthma only: Include up to $75/year for environmental (home) assessment (requires Prior Approval)
- Laboratory tests services that are linked to asthma or COPD primary diagnosis code, e.g., allergy sensitivity testing, Arterial Blood Gas (ABG)

Please note, if you have complications from asthma or COPD, and use an emergency department, have a Hospital stay, or get lung resection/transplant, services will be subject to standard Out-of-Pocket Costs as outlined in your *Schedule of Benefits*.

4. Coronary Artery Disease (CAD)

Expanded Pharmacy coverage is limited to $0 Out-of-Pocket Cost for generic medications and a reduction in Out-of-Pocket Cost for preferred brand medications as outlined below. If the Plan applies a Deductible and Coinsurance for preferred brand medications, the Deductible is waived and the Coinsurance is reduced by half.

Medications that are on the formulary and are approved by the FDA for treatment of CAD, diabetes, hypertension, and hyperlipidemia are covered under this reduced Out-of-Pocket Cost benefit.

The following services related to CAD are covered with $0 Out-of-Pocket Cost when performed by a Plan Provider (unless otherwise noted):

- Office visits to a Primary Care Provider for routine management of CAD
- Cardiology consultation and routine management of CAD
- Electrocardiogram (ECG)
- Cardiac rehabilitation (Deductible is waived and the Coinsurance is reduced by half)
- Laboratory services linked to a hyperlipidemia primary diagnosis code

Cardiac rehabilitation related to CAD is covered at a 50% reduction in cost-sharing when performed by a Plan Provider.

Please note, if you have complications from CAD and use an emergency department, have a Hospital stay, or get a cardiac procedure not listed above (e.g., cardiac stress test, cardiac catheterization, echocardiogram, intravascular ultrasound, nuclear perfusion imaging, PET (positron emission tomography) imaging, angioplasty, coronary artery bypass graft), services will be subject to standard Out-of-Pocket Costs as outlined in your *Schedule of Benefits*.

If you pay for a service that you think should be covered under the *Chronic Illness Support Program*, or if you have questions about the program, contact Member Services at 1-855-624-6463.

3. ENROLLMENT AND ELIGIBILITY

Important Note: If this Plan is purchased through the Federally Facilitated Marketplace (FFM), enrollment in and eligibility for coverage under the Plan is subject to the rules of the FFM. You must begin the enrollment process through the FFM to be eligible for Catastrophic coverage.

A. Enrollment

You can enroll under the Plan during an annual Open Enrollment Period or a Special Enrollment Period. The only time you are able to make changes to your Plan is during the annual Open Enrollment Period or when you are eligible for a Special Enrollment Period.

1. 10-Day Agreement Review

   At the start of each Plan year, you will have 10 days from the effective date of your coverage to end your Agreement. Your Premium will be refunded if you cancel during this period. See the first page of your Agreement or contact Member Services to learn more about this "free look" period.

2. Special Enrollment

   During the year, if you have certain qualifying life-changing events, you and your Dependents can enroll for coverage under the Plan through "Special Enrollment." Special qualifying events, such as birth or adoption of a child, marriage, loss of other insurance coverage due to divorce or change in employment, or changes in eligibility for other public service programs, will trigger a Special Enrollment Period. For a full list of these qualifying events, visit www.healthoptions.org or contact Member Services.

   To take advantage of a Special Enrollment Period, you must complete the enrollment process by visiting the Federally Facilitated Marketplace to complete information about a change in circumstances or by visiting www.healthoptions.org to complete a "Special Enrollment Period Qualifying Event" web form. If you do not have access to the internet, you may also submit a completed paper *Application*. You must complete the enrollment process for new Dependent coverage within 60 days of the qualifying event.

   If you become a Member or add new Dependents through a Special Enrollment Period, the effective date of coverage depends on the type and date of event, as well as when CHO receives premium payment and the completed enrollment information. You will be notified of the effective date of coverage.

B. Member and Dependent Eligibility

If this Plan is being offered through the Federally Facilitated Marketplace (FFM), the FFM will determine who is eligible to enroll in the Plan. The FFM may have additional or different eligibility criteria than those described in this Agreement. If you need to make changes to your plan, you will need to contact the FFM directly or visit healthcare.gov. If this Plan is being offered direct from CHO, CHO will determine who is eligible to enroll in the Plan according to state and federal law. If you need to make changes to your plan, you will need to contact CHO directly.

1. Member Eligibility

   You are a Member of this Plan if you are enrolled as a Subscriber or Dependent of the Subscriber. If this Plan is being offered through the FFM, the FFM will make eligibility determinations in accordance with applicable law and based upon your *Application*. If you purchased this Plan direct from CHO, we will make eligibility determinations in accordance with applicable law, your *Application*, and payment of the initial Premium. Subscribers must reside in Maine.

2. Dependent Eligibility

   In order to be a Dependent, a Member must be:

   a. The Subscriber's legal spouse or legal domestic partner (a legal domestic partnership exists when it meets all the criteria provided in the Maine Insurance Code for domestic partnerships).
   b. A child, who is under age 26, of the Subscriber or the Subscriber's spouse or domestic partner, including newborn children, biological children, adopted children or children Placed for Adoption, stepchildren, children placed in foster care, and children for whom the Subscriber or the Subscriber's spouse/domestic partner is a legal guardian.
   c. An unmarried child of the Subscriber or the Subscriber's spouse/domestic partner who, as of the date the child turns age 26 or older, is mentally or physically unable to earn his or her own living and is chiefly financially dependent on the Subscriber.
   d. A child who is eligible as a Dependent because of a Qualified Medical Support Order ("QMSO") or other court or administrative order requiring medical coverage for a child of a Subscriber or spouse/domestic partner of the Subscriber. Such child will be eligible for medical coverage as stated in the QMSO or other court or administrative order.

   A QMSO is a judgment, decree, or order issued by a court or administrative agency that meets certain federal law requirements.

3. Proof of Eligibility

   CHO or the FFM may require the Subscriber to submit reasonable evidence of eligibility for Dependent coverage from time to time. Failure to provide this information may result in termination of coverage for a Dependent. Please contact CHO if you have questions about what evidence CHO may require.

C. Effective Dates

Your coverage will begin under the Plan on the effective date of your Agreement. You will be informed of the effective date. You will not receive Benefits for any services, supplies, or equipment provided to you or received by you before your individual effective date of coverage under this Agreement. If you have an Inpatient Stay before and on your effective date, your coverage will begin on the effective date of this Agreement. Inpatient Stays, services, supplies, or equipment provided before your effective date are not covered.

1. New Dependents

   New Dependents may be added by paying the applicable Premium and completing enrollment for:

   a. Marriage or beginning of a legal domestic partnership (and the spouse's/domestic partner's child(ren), if applicable)

      Coverage is effective immediately on the date of marriage or legal domestic partnership or if other coverage is in force the effective date will be when the other coverage ends. A completed *Application* is required within 60 days from the date of marriage or legal domestic partnership.

2. Birth or adoption

   A newborn is automatically covered for 31 days from the moment of birth unless the Subscriber notifies us that the newborn will not be covered under this Agreement. For continuous coverage beyond 31 days from birth, you must submit a completed *Application* to us within this 60-day period.

   For purposes of this section, the term "newborn" includes a newly born child of the insured or Subscriber or a newly born child of a Dependent child of the insured or Subscriber. Grandchildren of the insured or Subscriber are not eligible for coverage beyond the initial 31-day period following birth.

   Coverage for routine newborn care will be attributed to the mother's coverage until the mother's discharge. If the newborn remains in the Hospital after the mother is discharged, or if services beyond the scope of routine newborn care are provided, those services will be subject to Deductible and Coinsurance, if applicable, of the newborn. See the Obstetrical Services and Newborn Care section under Covered Services (4.B).

   a. Adoption or Placement for Adoption

      An adopted child or child Placed for Adoption is covered for 31 days from the date of adoption or Placement for Adoption unless the Subscriber notifies us that the adopted child or child Placed for Adoption will not be covered under this Agreement. For continuous coverage beyond 31 days from adoption or Placement for Adoption, you must submit a completed *Application* to us within 60-days.

   b. Legal guardianship

      Coverage is effective the date of the court order appointing the guardian if the completed *Application* is received within 60 days from the date of the court order.

   c. Subscriber becomes legally responsible for a Dependent's health care coverage

      Coverage is effective the date of the court order or other event creating such legal responsibility if the completed *Application* is received within 60 days from the date of the court order or event.

   d. Other situations

      Other types of Dependents allowed by law must be enrolled as required by law. You may contact CHO Member Services or the FFM, as applicable, if you have questions.

Except for the 31 days of automatic coverage after the birth of a child, adoption, or Placement for Adoption as described above, to obtain Dependent coverage under this section, you must be able to provide notice and evidence of Dependent status satisfactory to CHO or the FFM, as applicable, within 60 days after an event listed in this section should we require it. We may also request evidence of Dependent status at other times.

If you fail to submit a completed *Application* during the 60-day period as outlined above, your Dependent can be added during the annual Open Enrollment Period, or other enrollment period required by law, by submitting a completed *Application*.

3. Eligibility Changes

   It is the Subscriber's responsibility to promptly inform CHO and the FFM, as applicable, of all changes that affect Member and Dependent eligibility.

D. Paying your Membership Premium

When you purchase coverage under the Plan, you will be billed for the Premium on a monthly basis. Payment for the Premium is due the first day of each month for which coverage is provided.

1. Members Not Receiving Tax Credits

   If you do not pay the Premium in full when due, you will have a 31-day grace period to pay the outstanding Premium owed. During the grace period, your coverage will not lapse. If we do not receive the full Premium after the end of the grace period, then we may terminate your coverage under the Plan and this Agreement. Except as otherwise allowed under this Agreement, we will not allow reinstatement after the grace period ends. We reserve the right to take necessary steps to collect outstanding Premiums.

2. Members Receiving Tax Credits

   Members who receive Advanced Payments of Premium Tax Credits (within the Federally Facilitated Marketplace) and have paid at least one month's Premium, but who subsequently fail to pay the Premium in full, will have a three-month grace period to submit payment in full of outstanding Premium due. CHO will pay appropriate claims for the first month of the grace period. CHO may hold claims during the remainder of the grace period.

   CHO will stop holding claims when the full Premium amount owed is paid. If the full amount of the outstanding Premium is not paid by the end of the grace period, CHO will terminate coverage under the Plan and this Agreement, and the Member will be responsible for paying for any services received during the final two months of the grace period.

3. Third-Party Payment of Premiums

   There may be instances where someone other than the Member pays the Member's Premium under this Agreement. This is sometimes called "third-party payment of Premiums."

CHO will permit Members' family members, Designees, and legal representatives to pay Premiums on behalf of Members. CHO will also permit Ryan White HIV/AIDS Programs; Indian tribes, tribal organizations, and urban Indian organizations; state and federal government programs; and private, nonprofit foundations approved by CHO to make Premium payments on behalf of CHO Members who satisfy defined criteria.

If a Provider, pharmaceutical company, or other commercial health care entity submits a payment for a Premium on behalf of a Member, CHO reserves the right to reject such payments, whether paid directly or indirectly by the entity. We will notify you if we have rejected this type of payment. If we reject a third-party Premium payment, you will continue to owe any Premium due as required under this Agreement.

E. Rebates

To the extent required by law, CHO may issue a rebate of a portion of your Premium back to you.

F. Parental Notification

If the Member is a parent of a Dependent child, the Member may request that MCHO provides:

1. An explanation of the payment or denial of any claim filed on behalf of the Dependent child, except to the extent that the Dependent child has the right to withhold consent and does not affirmatively consent to notifying the parent;
2. An explanation of any proposed change in the terms of this Agreement; and
3. Reasonable notice that this Agreement may lapse, but only if the Member has provided MCHO with the address where notice should be delivered.

The Member may also provide MCHO with information about a claim relating to the Member's Dependent child so that MCHO may process the claim.

4. COVERED SERVICES

This section contains information on the Covered Services under your Plan. Member Out-of-Pocket Cost information (Copayments, Coinsurance, and Deductibles) that apply to your Plan are listed in your *Schedule of Benefits*. Benefits are administered on a Calendar Year basis.

A. Requirements

To be covered and be eligible for Benefits under the Plan, all services and supplies must meet all of the following requirements:

1. Listed as a Covered Service;
2. Be rendered by a Provider within the scope of such Provider's license or certification;
3. Be Medically Necessary;
4. Not be excluded in the "Exclusions from Benefits" section (see section 5);
5. Be received while an active Member of the Plan; and
6. Receive Prior Approval, if applicable. This requirement does not apply to care needed in a Medical Emergency and certain other services (see section 2.E).

Services that are not Covered Services, and services related to non-Covered Services, are not eligible for Benefits.

B. Covered Services

The following services are Covered Services under the Plan:

1. Allergy Testing and Injections. The Plan provides Benefits for allergy testing and injections. Coverage includes allergy shots for desensitization.
2. Ambulance Service. The Plan provides Benefits for local transportation by a licensed vehicle that is specially designed and equipped to transport the sick and injured. This service is covered only when used locally to or from a Hospital when other transportation would endanger your health.

   The Plan provides Benefits only for ambulance transportation to the nearest Hospital that can provide the required care you need.

   Non-Emergency Ambulance Transport

   The Plan provides Benefits for local, non-emergency ambulance service between Hospitals or other covered health care facilities or from a covered facility to your home when Medically Necessary. All other non-emergency transport is excluded. Prior Approval may be required.

   Please visit www.healthoptions.org for more information on services that require Prior Approval or call Member Services at 1-855-624-6463 (TTY/TDD: 711).

   Reimbursement for Covered Services under this provision 4.B.2 will be provided directly to the ambulance service provider.

3. Ambulatory Surgery Centers. The Plan provides Benefits for certain Covered Services provided by Ambulatory Surgery Centers. Covered Services vary according to the scope of a specific Ambulatory Surgical Center's license.

4. Anesthesia Services. The Plan provides Benefits for anesthesia only if administered while a Covered Service is being provided. An exception is provided under section 4.B.16.

5. Asthma Education. The Plan provides Benefits for CHO-approved asthma education programs for Members and their families.

6. Autism Spectrum Disorders Treatment. To the extent required by Maine law, the Plan provides Benefits for the following services for the treatment of Autism Spectrum Disorders for Members:

   a. Any assessments, evaluations, or tests by a licensed Physician or licensed psychologist to diagnose whether a Member has an Autism Spectrum Disorder.

   b. Habilitative or rehabilitative services, including Applied Behavior Analysis or other professional or counseling services necessary to develop, maintain, and restore the functioning of an individual to the extent possible. To be covered by the Plan, Applied Behavior Analysis must be provided by a person professionally certified by a national board of behavior analysts or performed under the supervision of a person professionally certified by a national board of behavior analysts.

   c. Counseling services provided by a licensed psychiatrist, psychologist, clinical professional counselor, or clinical social worker.

   d. Therapy services provided by a licensed or certified speech therapist, occupational therapist, or physical therapist.

   e. Prescription drugs.

   The Primary Care Provider, an appropriately credentialed treating specialist, a psychiatrist, a pediatrician with a specialty in behavioral-developmental pediatrics, a neurologist with a specialty in neurology, or a licensed psychologist with training in psychology must determine that a service under this section is Medically Necessary and is consistent with nationally recognized treatment standards for the condition such as those set forth by the American Academy of Pediatrics. Such determination must be renewed annually.

   The Provider must submit a treatment plan, and such treatment plan must be updated no more frequently than on a semi-annual basis.

   Coverage for prescription drugs for the treatment of Autism Spectrum Disorders will be determined in the same manner as coverage for prescription drugs for the treatment of any other illness or condition.

7. Blood Transfusions. The Plan provides Benefits for blood transfusions including the cost of blood, blood plasma, and blood plasma expanders, and administrative costs of autologous blood pre-donations.

8. Breast Cancer Treatment. The Plan provides Benefits for breast cancer treatment, including prostheses and the following services:

   a. Inpatient care for a mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer is covered for a period of time determined to be Medically Necessary by the attending Physician, in consultation with you.
   b. If you elect breast reconstruction following mastectomy surgery, the Plan covers reconstruction in the manner you and your Provider choose.

   Coverage includes reconstruction of the breast on which the mastectomy was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance. See section 4.B.9.

   As required by Maine and federal law, the Inpatient length of stay for a mastectomy, lumpectomy, or a lymph node dissection for the treatment of breast cancer will be decided by the attending Provider in consultation with you.

9. Breast Reconstruction Surgery. If a Member receives Benefits in connection with a mastectomy and the Member elects breast reconstruction in connection with such mastectomy, to the extent required by federal law, the Plan provides Benefits for, in a manner determined in consultation with the attending Physician and the Member:

   a. All stages of reconstruction of the breast on which a mastectomy has been performed;

   b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

   c. Prostheses and physical complications of the mastectomy, including lymphedemas.

10. Breast Reduction Surgery and Symptomatic Varicose Vein Surgery. To the extent required by Maine law, the Plan provides Benefits for breast reduction surgery and symptomatic varicose vein surgery determined to be Medically Necessary by a Physician.

11. Chemotherapy Services. The Plan provides Benefits for antineoplastic drugs and associated antibiotics and their administration when they are administered by parenteral means such as intravenous, intramuscular, or intrathecal means. This does not include the use of drugs for purposes not specified on their labels unless approved by us for medically accepted indications or as required by law. Any FDA treatment investigational new drugs are not covered unless approved by us for medically accepted indications or as required by law. The Plan provides coverage for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells that is equivalent to the coverage provided for intravenously administered or injected anticancer medications.

12. Chiropractic Care/Therapeutic, Adjustive and Manipulative Services. The Plan provides Benefits for Medically Necessary chiropractic care. The Plan provides Benefits for therapeutic adjustments and manipulations for treating acute musculo-skeletal disorders. These services may be rendered by a Provider within the scope of such Provider's license or certification and are not limited to chiropractic doctors. No benefits are provided for ancillary treatment such as massage therapy, heat and electrostimulation unless in conjunction with an active course of treatment.

    Prior Approval is required after the 32nd visit. Please visit www.healthoptions.org for more information on services that require Prior Approval or call Member Services at 1-855-624-6463 (TTY/TDD: 711).

13. Clinical Trials. To the extent required by Maine and federal law, the Plan provides Benefits for items and services you receive as a participant in an approved clinical trial that would normally be covered under the Plan for Members who are not enrolled in a clinical trial.

    An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The Plan provides Benefits under this section for the following clinical trials:

    a. Trials approved or funded by one or more of the following:

        i. The National Institutes of Health (NIH)
        ii. The Centers for Disease Control and Prevention
        iii. The Agency for Health Care research and Quality
        iv. The Centers for Medicare and Medicaid Services
        v. Cooperative group or center of any of the entities described in (i) through (iv) or the Department of Defense or Department of Veterans Affairs
        vi. A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants
        vii. Any of the following in (1) through (3) below if the study or investigation has been reviewed and approved through a system of peer review that the U.S. Department of Health and Human Services determines to be comparable to the system of peer review of studies and investigations used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:

            1. Department of Veterans Affairs
            2. Department of Defense
            3. Department of Energy

    b. Studies or investigations done as part of an investigational new drug application reviewed by the FDA

    c. The study or investigation is a drug trial that is exempt from having such an investigational new drug application

    A "life-threatening disease or condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

    The Plan may require that you participate in the trial through a Plan Provider if a Plan Provider will accept you as a participant in the trial.

    The Plan may deny Benefits for:

    a. The Investigational item, device, or service, itself
    b. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the Member
    c. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis

14. Colorectal Cancer Screenings. The Plan provides Benefits for colorectal cancer screenings as described in the guidelines of a national cancer society for asymptomatic Members who are:

    a. 50 years of age or older; or
    b. Less than 50 years of age and at high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of a national cancer society.

    For purposes of this section, "Colorectal Cancer Screening" means a colorectal cancer examination and laboratory test recommended by a Provider in accordance with the most recently published colorectal cancer screening guidelines of a national cancer society.

    If a colonoscopy is recommended as the colorectal cancer screening method and a lesion is discovered and removed during the colonoscopy, Benefits will be paid for the screening colonoscopy as the primary procedure. See section 2.B for information about free preventive services as defined in federal law.

15. Contraceptives/Family Planning. The Plan provides Benefits for family planning and Benefits for prescription contraceptive drugs and devices approved by the FDA to prevent pregnancy, including related consultations, examinations, procedures, and medical services provided on an Outpatient basis. Coverage includes sterilization procedures, and patient education and counseling. See section 2.B for information about free preventive services as defined in federal law.

16. Dental Procedures. The Plan provides Benefits for general anesthesia and associated facility charges for the Medically Necessary Hospital or surgical day care facility charges and administration of general anesthesia administered by a licensed anesthesiologist or anesthetist for dental procedures performed on a Member who:

    a. Is a child under the age of 6 who is determined by a licensed dentist in conjunction with a licensed Physician to have a dental condition of significant dental complexity which requires certain dental procedures to be performed in a surgical day care facility or Hospital setting; or
    a. Is a person who has exceptional medical circumstances or a developmental disability as determined by a licensed Physician which place the Member at serious risk.

    The Plan **does not** provide Benefits under this section for any dental procedures or the dentist's fee.

17. Dental Services. The Plan provides Benefits for Medically Necessary dental services resulting from an accidental injury to sound natural teeth and gums when the course of treatment for the Accidental Injury is received within 6 months of the date of the injury or the Member's effective date of coverage, whichever is later. Treatment made necessary due to injury to the jaw and oral structures other than teeth shall be covered without time limit. Coverage will be subject to such other terms and conditions of the Plan that may apply.

    The Plan does not provide Benefits for services for dental damage that occurs as a result of normal activities of daily living or extraordinary use, such as injury to teeth sustained due to biting or chewing.

    The Plan provides Benefits for the surgical removal (extraction) of erupted teeth before radiation therapy for malignant disease. Benefits are limited to the surgeon's fee for the

surgical procedure, intravenous sedation furnished by the operating dentist or oral surgeon, and general anesthesia furnished by a licensed anesthesiologist or anesthetist who is not the operating dentist or oral surgeon. The Plan does not provide Benefits for related preoperative or postoperative care, including medical, laboratory, and x-ray services. Prior Approval is required. Please visit www.healthoptions.org for more information on services that require Prior Approval or call Member Services at 1-855-624-6463 (TTY/TDD: 711).

The Plan provides Benefits for the surgical correction of a facial bone fracture (not to include the portion of upper and lower jaws that contain the teeth, except as otherwise covered in Section 4.B) and surgical removal of a lesion or tumor by a dentist or oral surgeon are covered to the same extent as any other surgical procedure covered under this Plan. Prior Approval is required. Please visit www.healthoptions.org for more information on services that require Prior Approval or call Member Services at 1-855-624-6463 (TTY/TDD: 711).

18. Diabetes Services and Supplies. The Plan provides Benefits for the following diabetic services and supplies that are determined to be Medically Necessary by the Member's treating Provider:

    a. Maine Department of Health and Human Services-approved Outpatient self-management training and educational services used to treat diabetes;
    b. Insulin;
    c. Insulin pumps;
    d. Oral hypoglycemic agents;
    e. Glucose monitors;
    f. Test strips;
    g. Syringes; and
    h. Lancets.

19. Diagnostic Services. The Plan provides Benefits for Diagnostic Services, including diagnostic laboratory tests and x-rays, when they are ordered by a Provider to diagnose specific signs or symptoms of an illness or injury or when the services are part of preventive services covered under this Agreement. Services covered under this section include the services of a Physician with a specialty in radiology.

    Certain imaging services require Prior Approval. Please visit www.healthoptions.org for more information on services that require Prior Approval or call Member Services at 1-855-624-6463 (TTY/TDD: 711).

20. Dialysis. The Plan provides Benefits for kidney dialysis on an Inpatient or Outpatient basis, or at home. You must apply for Medicare when federal law permits Medicare to be the primary payer for dialysis. You must also pay any Medicare premium. When Medicare is primary (or would be primary if the Member were timely enrolled) the Plan provides Benefits only to the extent payments would exceed what would be payable by Medicare. Your PCP should make all arrangements for dialysis care. Coverage for dialysis in the home includes nondurable medical supplies, drugs, and equipment.

    To be covered, dialysis services under this section must be ordered by a Physician.

21. Durable Medical Equipment and Prostheses. The Plan provides Benefits for the rental or purchase of Durable Medical Equipment. Whether you rent or buy the equipment, the Plan provides Benefits for the least expensive equipment necessary to meet your medical needs. If you rent the equipment, we will make monthly payments only until our share of the reasonable purchase price of the least expensive equipment is paid or until the equipment is no longer necessary, whichever comes first. Benefits for replacement or repair of purchased Durable Medical Equipment are subject to Prior Approval.

    Please visit www.healthoptions.org for more information on services that require Prior Approval or call Member Services at 1-855-624-6463 (TTY/TDD: 711).

    The Plan does not provide Benefits for the repair or replacement of rented equipment.

    Supplies are covered if they are necessary for the proper functioning of Durable Medical Equipment. Supplies for Durable Medical Equipment are not subject to any Durable Medical Equipment maximum applicable to the Plan.

    If more than one treatment, prosthetic device, or piece of Durable Medical Equipment may be provided for the disease or injury, Benefits will be based on the least expensive method of treatment, prosthetic device, or Durable Medical Equipment that can meet the Member's needs. Coverage for prosthetic devices is described at section 4.B.62.

22. Early Intervention Services. To the extent required by Maine law, the Plan provides Benefits for Early Intervention Services for children with an identified developmental disability or delay as described in the federal Individuals with Disabilities Education Act. Benefits are provided for children from birth up to 36 months of age.

    Coverage is only available for services rendered by the following types of licensed Providers:

    a. Occupational therapists;
    b. Physical therapists;
    c. Speech-language pathologists; and
    d. Clinical social workers.

    Prior Approval is required.

23. Emergency Services. The Plan provides Benefits for emergency department screening and treatment received for Medical Emergencies

    If you need follow-up care after you are treated in an emergency department, you should call your PCP.

    If you are hospitalized, you or your Designee should call 1-855-624-6463 (TTY/TDD: 711) within 48 hours or as soon as you can. However, if your attending emergency department Provider tells the Plan or your PCP within 48 hours that you have been hospitalized, then you do not need to call the Plan.

    If you are admitted as an Inpatient to the Hospital from the emergency department, you will not need to pay your Out-of-Pocket Costs for that emergency department visit.

    Emergency Services received outside the U.S.

    The Plan provides Benefits for Emergency Services provided in an emergency department or urgent care facility outside the U.S. The Plan provides Benefits for emergency transport

services to the nearest medical facility that can provide Emergency Services. The Plan does not provide Benefits for follow-up care that can wait until you return to the U.S.

The Plan does not provide Benefits for travel back to the U.S. or for repatriation.

24. Eye Examinations. The Plan provides Benefits for eye examinations received from an eye care Provider in the Provider's office. One routine vision exam, including refraction, to detect vision impairment by a Plan Provider every other Calendar Year is covered.

    A diabetic eye exam is covered once annually.

    The Plan does not provide Benefits for the fitting or purchase of eyeglasses or contact lenses, except as covered under "Eye Vision Hardware" (section 4.B.25) and "Pediatric Vision" (section 4.B.57).

25. Eye Vision Hardware. The Plan provides certain Benefits for contact lenses or eyeglasses needed for the eye conditions indicated below:

    a. Post cataract surgery with an intraocular lens implant (pseudophakes).
    b. Post cataract surgery without lens implant (aphakes).
    c. Keratonconus.
    d. Post retinal detachment surgery.

    No Benefits are provided for deluxe or designer glasses or frames. For details, please contact Member Services at 1-855- 624-6463 (TTY/TDD: 711).

    See section 4.B.57, below for information about Pediatric Vision Benefits.

26. Fluoride Treatment (Pediatric). The Plan provides Benefits for fluoride treatment for children when provided by a pediatrician/PCP.

27. Foot Care. The Plan provides Benefits for Medically Necessary podiatry services, including diabetic foot exam and systemic circulatory disease. Routine foot care is not covered.

28. Freestanding Imaging Centers. The Plan provides Benefits for covered Diagnostic Services performed by Freestanding Imaging Centers. All services must be ordered by a Provider.

    Certain imaging services require Prior Approval. Please visit www.healthoptions.org for more information on services that require Prior Approval or call Member Services at 1-855-624-6463 (TTY/TDD: 711).

29. Genetic Testing. The Plan provides Benefits for genetic testing or genetic counseling when Medically Necessary and Prior Approval has been obtained.

    Please visit www.healthoptions.org for more information on services that require Prior Approval or call Member Services at 1-855-624-6463 (TTY/TDD: 711).

30. Hearing Care. The Plan provides Benefits for hearing exams and wearable Hearing Aids for covered Members through age 18. Related items such as batteries, cords, and other assistive listening devices, including but not limited to, frequency modulation systems, are not covered.

    Hearing Aids are considered Durable Medical Equipment.

31. Home Health Care Services. The Plan provides Benefits for home health care services when services are performed and billed by a Home Health Agency. These services are covered if

hospitalization or confinement in a residential treatment facility would otherwise have been required. A Home Health Agency must submit a written plan of care to CHO, and then provide the services approved by CHO whether or not the patient is homebound.

The home health care services covered by the Plan include:

a. Visits by registered nurses and licensed practical nurses;
b. Physician or nurse practitioner home and office visits;
c. Visits by a registered physical, speech, occupational, inhalation, and dietary therapist;
d. Supportive services, including prescription drugs, medical and surgical supplies, and oxygen, but only to the extent that such services would have been covered if you remained in the Hospital; and
e. Visits by home health aides under the supervision of a registered nurse.

The Plan covers up to 90 home health care service visits per continuous 12-month period.

32. Home Infusion Therapy and Infusion. The Plan provides Benefits for infusion therapy when services are provided by a licensed Provider, facility, ambulatory infusion center, or home infusion therapy Provider, as appropriate. Supplies and equipment needed to appropriately administer infusion therapy are covered.

33. Hospice Care Services. The Plan provides Benefits for Hospice Care to Members diagnosed as having a terminal illness by a Physician with a life expectancy of less than twelve months. The Hospice plan of care will focus on palliative rather than curative treatment for the terminally ill Member. The care approach is holistic and interdisciplinary. Hospice is usually provided in the home, but in some circumstances may be provided in a facility.

    Prior Approval is required.

34. Hospice Respite Care. The Plan provides Benefits for Hospice Respite Care for up to one 48-hour period to allow the care giver of the Member receiving Hospice for relaxation.

    Prior Approval is required.

35. Hospice Services - Inpatient. The Plan provides Benefits for Inpatient Hospice Care at an acute care Hospital or Skilled Nursing Facility. The same services are covered for Inpatient Hospice Care as are covered under Inpatient Hospital services (section 4.B.41).

36. Inborn Errors of Metabolism. The Plan provides Benefits for metabolic formula for special modified low protein food products. Such food products must be specifically manufactured for patients with diseases caused by Inborn Errors of Metabolism. This Benefit is limited to those Members with diseases caused by Inborn Errors of Metabolism.

37. Independent Laboratories. The Plan provides Benefits for Diagnostic Services ordered by a Provider and performed by Independent Laboratories.

38. Infant Formulas. To the extent required by Maine law, the Plan provides Benefits for Medically Necessary amino acid-based elemental Infant Formula for Members two years of age or younger, without regard to the method of delivery of the formula. Coverage will be provided under this section when a Physician Provider has documented that the amino acid-based elemental infant formula is Medically Necessary, such that:

    a. The amino acid-based elemental infant formula is the predominant source of nutritional intake at a rate of 50% or greater; and

b. Other commercial infant formulas including cow milk-based and soy milk-based formulas have been tried and have failed or are contraindicated.

In addition, coverage will only be provided to a Member under this section when a Physician Provider has diagnosed, and through medical evaluation has documented, one of the following conditions:

a. Symptomatic allergic colitis or proctitis;
b. Laboratory- or biopsy-proven allergic or eosinophilic gastroenteritis;
c. A history of anaphylaxis;
d. Gastroesophageal reflux disease that is nonresponsive to standard medical therapies;
e. Severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by a medical provider;
f. Cystic fibrosis; or
g. Malabsorption of cow milk-based or soy milk-based infant formula.

CHO may require that a Physician Provider confirm and document at least annually that the formula remains Medically Necessary.

The cost-sharing for formula is treated as Durable Medical Equipment for purposes of the *Schedule of Benefits.*

39. Inhalation Therapy. The Plan provides Benefits for inhalation therapy by a licensed therapist for the administration of medications; gases such as oxygen, carbon dioxide, or helium; water vapor; or anesthetics.

40. In-Home Biometric Monitoring. The Plan provides Benefits for HIPAA-compliant In-Home Biometric Monitoring related to congestive heart failure ("CHF") and chronic obstructive pulmonary disease ("COPD") when Medically Necessary and with Prior Approval.

41. Inpatient Hospital Services. The Plan provides Benefits for the following Inpatient Hospital services:

a. Room and board, including general nursing care, special duty nursing, and special diets;
b. Use of intensive care or coronary care unit;
c. Diagnostic Services;
d. Medical, surgical, and central supplies;
e. Anesthesia;
f. Physician services;
g. Treatment services;
h. Maternity admissions;
i. Hospital ancillary services including but not limited to use of an operating room, anesthesia, laboratory, x-ray, occupational therapy, physical therapy, speech therapy, inhalation therapy, and radiotherapy services;
j. Phase I cardiac rehabilitation;
k. Medication used when you are an Inpatient, such as drugs, biologicals, and vaccines. This does not include the use of drugs for purposes not specified on their labels unless approved by us for Medically Necessary accepted indications or as required by law. Any FDA treatment investigational new drugs are not covered unless approved by us for Medically Necessary accepted indications or as required by law;
l. Blood and blood derivatives;

m. Durable Medical Equipment, Prostheses, and Orthotic Devices; and
n. Newborn care, including routine well-baby care.

The Plan provides Benefits for a private room if Medically Necessary.

The Plan will stop providing Benefits for an Inpatient Stay at a Hospital after the earliest of:

a. Your discharge as an Inpatient;
b. Reaching any Benefit limits or maximums; and
c. You being notified by a Physician, appropriate Hospital staff, or CHO that you are no longer eligible for continued Inpatient Stay at a Hospital.

42. Leukocyte Antigen Testing to Establish Bone Marrow Donor. To the extent required by Maine law, the Plan provides Benefits for laboratory fees arising from human leukocyte antigen testing performed to establish bone marrow transplantation suitability if the following requirements are met:

    a. The Member must meet the criteria for testing established by the National Marrow Donor Program, or its successor organization;
    b. The testing must be performed in facility accredited by a national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists and is certified under the federal Clinical Laboratories Improvement Act of 1967; and
    c. At the time of testing, the Member must complete and sign an informed consent form that authorizes the test results to be used for participation in the National Marrow Donor Program or its successor organization, and acknowledges a willingness to be a bone marrow donor if a suitable match is found.

43. Massage Therapy. The Plan provides Benefits for massage therapy when services are part of an active course of treatment and the services are performed by a covered Provider. A massage therapist is not a covered Provider.

44. Medical Care. The Plan provides Benefits for medical care and services including office visits and consultations, medical exams, management of therapy, surgical services, anesthesia, injections, Hospital and Skilled Nursing Facility visits, and pediatric services.

45. Medical Supplies. The Plan provides Benefits for medical supplies furnished by a Provider in the course of delivering Medically Necessary services. This Benefit does not apply to bandages and other disposable items that may be purchased without a prescription, except for syringes which are Medically Necessary for injecting insulin or a drug prescribed by a Physician.

46. Mental Health and Substance Abuse. The Plan provides Benefits for Inpatient, Outpatient, and Day Treatment Program services for mental health and substance abuse when you receive them from a Provider.

    If you receive services from a Community Mental Health Center or Substance Abuse Treatment Facility, services must be:

    a. Supervised by a licensed Physician, licensed clinical psychologist, or licensed clinical social worker; and

b. Part of a plan of treatment for furnishing such services established by the appropriate staff member.

The Plan provides Benefits for only the following mental health and substance abuse treatment services:

a. Room and board, including general nursing;
b. Prescription drugs, biologicals, and solutions administered to inpatients;
c. Supplies and use of equipment required for detoxification and rehabilitation;
d. Diagnostic and evaluation services;
e. Intervention and assessment;
f. Facility-based professional and ancillary services;
g. Individual, group, and family therapy and counseling;
h. Medication checks;
i. Psychological testing; and
j. Emergency treatment for the sudden onset of a mental health or substance abuse condition requiring immediate and acute treatment.

Outpatient visits for substance abuse conditions may be furnished during the acute detoxification stage of treatment or during stages of rehabilitation.

Benefits, cost-sharing and managed care requirements will be the same for Mental Health and Substance Abuse Services as for other medical or surgical coverage as described in federal law.

Please visit www.healthoptions.org for more information on services that require Prior Approval or call Member Services at 1-855-624-6463 (TTY/TDD: 711).

47. Morbid Obesity. The Plan provides Benefits for surgery for an intestinal bypass, gastric bypass, or gastroplasty for treatment of Morbid Obesity.

    Prior Approval is required. Please visit www.healthoptions.org for more information on services that require Prior Approval or call Member Services at 1-855-624-6463 (TTY/TDD: 711).

    The Plan does not provide Benefits for weight loss medication.

48. Nutritional Counseling. The Plan provides Benefits for nutritional counseling when required for a diagnosed medical condition. Prior Approval is required after the 6th visit.

49. Obstetrical Services and Newborn Care. The Plan provides Benefits for pre-natal, delivery and post-partum care, including Physician services for delivery of a newborn, ultrasounds, medical care, operating room for delivery of a newborn, care of a newborn and complications of pregnancy. The Plan provides Benefits for home deliveries by a certified nurse midwife.

    Routine newborn care does not include any services provided after the mother has been discharged from the Hospital. All other Plan provisions such as Deductible and Coinsurance, if applicable, will apply to the newborn if the mother is discharged and the newborn remains in the Hospital.

    The Plan will not restrict Benefits for a mother or newborn child for any Hospital length of stay due to childbirth to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. This does not prohibit the mother or newborn from being

discharged earlier should the attending Provider deem appropriate after consulting with the mother.

Home-birth

Home birth services are covered when performed by a licensed Provider within the scope of the Provider's license.

50. Occupational Therapy. The Plan provides Benefits for short-term occupational therapy on an Outpatient basis for conditions that are subject to significant improvement.

    Prior Approval is required after the 24th visit. Please visit www.healthoptions.org for more information on services that require Prior Approval or call Member Services at 1-855-624-6463 (TTY/TDD: 711).

    No Benefits are provided for treatments such as: massage therapy, paraffin baths, hot packs, whirlpools, or moist/dry heat applications unless performed by a licensed Provider in conjunction with an active course of treatment.

51. Off-Label Use of Prescription Drugs. To the extent required by Maine law, the Plan provides Benefits for off-label use of prescription drugs for cancer, HIV, and AIDS.

52. Office Visits. The Plan provides Benefits for office visits to Providers. Services rendered during an office visit, such as medical exams, management of therapy, injections, surgery and anesthesia, may be subject to additional charges beyond office visit Out-of-Pocket Costs.

53. Organ and Tissue Transplants. As described in this section, the Plan provides Benefits for organ and tissue transplant procedures. You must receive Prior Approval from us before you are admitted for any transplant procedure.

    Please visit www.healthoptions.org for more information on services that require Prior Approval or call Member Services at 1-855-624-6463 (TTY/TDD: 711).

    Covered transplants include: small bowel, heart, heart/lung, lung, islet tissue, liver, adrenal gland, bone, cartilage, muscle, skin, tendon, heart valve, blood vessel, parathyroid, kidney, cornea, allogeneic bone marrow, pancreas, and autologous bone marrow.

    The Plan provides Benefits for organ and tissue transplant donors only if (1) the donor is a Member or the donor does not have similar Benefits available from another source, and (2) the recipient is a Member. When the donor is eligible for coverage under the Plan, the Plan provides Benefits for medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy, after benefits for the recipient's expenses have been paid.

54. Orthotic Devices. The Plan provides Benefits for certain Orthotic Devices, including but not limited to orthopedic braces, back or surgical corsets, and splints. The Plan does not provide Benefits for the following whether available over the counter or by prescription: arch supports, shoe inserts, other foot support devices, orthopedic shoes (unless attached to a brace), support hose, and garter belts.

    The Plan provides Benefits for certain orthotic devices used for diabetic care with Prior Approval. Orthotic devices prescribed for diabetic care are not part of the Chronic Illness Support Program.

Unless otherwise noted, the Plan does not provide Benefits for the following whether available over the counter or by prescription: arch supports, shoe inserts, other foot support devices, orthopedic shoes (unless attached to a brace), support hose, and garter belts.

55. Outpatient Services. The Plan provides Benefits for the following Hospital Outpatient, Federally Qualified Health Center and Rural Health Clinic services:

    a. Medical exams;
    b. Management of therapy;
    c. Injections;
    d. Emergency department services/emergency care;
    e. Removal of sutures;
    f. Application or removal of a cast;
    g. Diagnostic Services;
    h. Surgical services;
    i. Anesthesia;
    j. Removal of impacted or unerupted teeth;
    k. Endoscopic procedures;
    l. Blood administration;
    m. Radiation Therapy; and
    n. Outpatient rehabilitation programs including covered Phase II cardiac rehabilitation, physical rehabilitation, head injury rehabilitation, pulmonary rehabilitation, and hemodialysis training. Benefits for these services have special requirements. Please check with us to see if you are eligible for these Benefits.

56. Parenteral and Enteral Therapy. The Plan provides Benefits for parenteral and enteral therapy. Supplies and equipment needed to appropriately administer parenteral and enteral therapy are covered. Nutritional supplements for the sole purpose of enhancing dietary intake are not covered unless they are given in conjunction with enteral therapy.

57. Pediatric Vision. The Plan provides Benefits for Diagnostic Services, eyewear (either contact lenses or basic glasses and frames) once per year, and other vision services (optional lenses and treatments) for Members under the age of 19.

    Eyewear includes standard plastic (CR39) eyeglass lenses with factory scratch coating at no additional cost (up to 55 mm); basic frames; and contact lenses.

    The Plan provides benefits, with no cost sharing, for visual acuity screening for children once between the ages of 3 and 5 years to detect the presence of amblyopia or its risk factors. This is a preventive service as defined in section 2.B of this Agreement.

    No Benefits are provided for deluxe or designer glasses or frames. No Benefits are provided for the replacement of lenses, frames or contacts.

58. Physical Therapy. The Plan provides Benefits for short-term physical therapy on an Outpatient basis for conditions that are subject to significant improvement.

    Prior Approval is required after the 24th visit. Please visit www.healthoptions.org for more information on services that require Prior Approval or call Member Services at 1-855-624-6463 (TTY/TDD: 711).

No Benefits are provided for treatments such as: massage therapy, paraffin baths, hot packs, whirlpools, or moist/dry heat applications unless performed by a licensed Provider in conjunction with an active course of treatment.

59. Prescription Drugs. The Plan provides Benefits for FDA-approved prescription drugs and medicines listed on CHO's formulary and bought for use outside a Hospital. The prescription drug Out-of-Pocket Cost may vary depending on the tier that CHO assigns to the drug. Please see your *Schedule of Benefits* for details.

    A copy of the current formulary is available online at www.healthoptions.org or you may request a copy of the formulary by calling Member Services at 1-855-624-6463 (TTY/TDD: 711). The inclusion of a drug or related item on the tier listing is not a guarantee of coverage.

    Specific prescription drugs (or the prescribed quantity of a specific drug) may require Prior Approval. More information about which drugs require Prior Approval is available at www.healthoptions.org. On the formulary, medications that require Prior Approval for coverage are marked with "PA" next to the medication.

    Prescriptions must be used for their FDA-approved purpose unless Prior Approval for off-label use has been obtained.

60. Preventive Care and Well-Care Services. The Plan provides Benefits for certain preventive care and well-care services and items for adults and children that do not have symptoms of a medical condition for which services are being sought. Care required to treat a previously diagnosed medical condition will be considered under the "Diagnostic Services" section 4.B.19 and subject to the Out-of-Pocket Costs described in the *Schedule of Benefits*.

    Preventive care services and items listed in sections 2.B are covered by the Plan with no Out-of-Pocket Costs for the Member when obtained In-Network. That means the Plan pays 100% of the Maximum Allowable Charge. These services are:

    a. Services with an "A" or "B" rating from the United States Preventive Services Task Force;
    b. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunizations Practices of the Centers for Disease Control and Prevention;
    c. Preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (includes diabetes screening and lead screening for children); and
    d. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration (including annual gynecological exams and pap smears).

    Preventive care that is not included in the four categories listed above will be subject to Out-of-Pocket Costs described in the *Schedule of Benefits*. You may call Member Services at 1-855-624-6463 (TTY/TDD: 711) for additional information about these services.

    If a preventive care service or item described in this section:

    a. Is billed separately (or is tracked as an individual encounter data separately) from an office visit, the Plan may impose Out-of-Pocket Costs with respect to the office visit.

b. Is **not** billed separately (or is tracked as an individual encounter data separately) from an office visit and the primary purpose of the office visit is for preventive care services or items, then the Plan will not impose Out-of-Pocket Costs with respect to the office visit.
c. Is **not** billed separately (or is tracked as an individual encounter data separately) from an office visit and the primary purpose of the office visit is **not** for preventive services or items, the Plan may impose Out-of-Pocket Costs with respect to the office visit.

61. Prostate Cancer Screenings. The Plan provides Benefits to male Members aged 50 to 72 for a yearly prostate cancer screening including 1) digital rectal examination, and 2) prostate-specific antigen tests. To be covered by the Plan, such services must be recommended by the Member's PCP as Medically Necessary.

    Prostate cancer screenings will be subject to Out-of-Pocket Costs.

62. Prosthetic Devices. The Plan provides Benefits for prosthetic devices to replace, in whole or in part, an arm or a leg. Prostheses include artificial limbs and prosthetic appliances. Coverage extends to such prosthetic devices, replacing in whole or in part an arm or a leg, that are determined by a Provider to be the most appropriate and least expensive model that will adequately meet the Member's medical needs. The Plan also covers repair or replacement of such prosthetic devices that is determined to be appropriate by a Provider.

    Coverage does not extend to prosthetic devices designed exclusively for athletic purposes.

63. Radiation Therapy. The Plan provides Benefits for Radiation Therapy.

64. Reconstructive Surgeries, Procedures, and Services. The Plan provides Benefits for reconstructive surgeries, procedures, and services, when considered to be Medically Necessary.

    Reconstructive surgeries, procedures, and services must meet at least one of the following criteria:

    a. Necessary due to Accidental Injury;
    b. Necessary for reconstruction or restoration of a functional part of the body following a covered surgical procedure for disease or injury;
    c. Necessary to restore or improve a bodily function;
    d. Necessary to correct a birth defect for covered Dependent children who have functional physical deficits; or
    e. Reconstructive breast surgery as described in section 4.B.9.

65. Screening Mammograms. The Plan provides Benefits for annual screening mammograms for asymptomatic Members who are women 40 years of age and older for the purpose of early detection of breast cancer and that consists of 2 radiographic views per breast. The Plan also provides Benefits for additional radiological procedures recommended by a Provider when the initial screening mammogram results are not definitive.

    The Plan provides Benefits, with no cost sharing, for screening mammography, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older. This is a preventive service as defined in section 2.B of this Agreement.

66. Second Opinions. The Plan provides Benefits for second opinions when provided by a Plan Provider with no practice association with the original Provider. Prior Approval is required for second medical/surgical opinions provided by a Non-Plan Provider.

Please visit www.healthoptions.org for more information on services that require Prior Approval or call Member Services at 1-855-624-6463 (TTY/TDD: 711).

67. Skilled Nursing Facility Services. The Plan provides Benefits for Inpatient Skilled Nursing Facility services with Prior Approval. The Plan does not cover Custodial Care.

68. Speech Therapy. The Plan provides Benefits for short-term speech therapy on an Outpatient basis for conditions that are subject to significant improvement. Benefits are subject to limits. Prior Approval is required after the 24th visit.

    Please visit www.healthoptions.org for more information on services that require Prior Approval or call Member Services at 1-855-624-6463 (TTY/TDD: 711).

    No Benefits are provided for:

    a. Deficiencies resulting from intellectual disabilities; or
    b. Dysfunctions that are self-correcting, such as language treatment for young children with natural dysfluency or developmental articulation errors.

69. Surgical Services. The Plan provides Benefits for surgical procedures, including services of a surgeon, Specialist, anesthesiologist, or anesthetist, and for preoperative and postoperative care.

70. Telemedicine Services. The Plan provides Benefits for telemedicine services if the service would be covered under the Plan were it provided through in-person consultation between the Member and a Provider. Coverage for services provided through Telemedicine must be determined in a manner consistent with coverage under the Plan for services provided through in-person consultation with a Provider.

    Telemedicine services are limited to the use of HIPAA-compliant, real-time interactive audio, video, or electronic media communications as a substitute for in-person consultation with Providers.

    Out-of-Pocket Costs for telemedicine services are the same as the Out-of-Pocket Costs for the same type of service if it had been provided through an in-person consultation.

71. Tobacco/Smoking Cessation. The Plan provides Benefits for FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications) with no out-of-pocket costs when prescribed by a health care provider (limited to two 90-day treatment regimens for prescription medications per Calendar Year). To be eligible for Benefits, prescription and over-the-counter medications must be prescribed by your Provider for tobacco cessation purposes.

    The Plan provides Benefits for tobacco cessation programs, follow-up education, counseling, and completion of a CHO-approved smoking cessation program. This is a preventive service as defined in section 2.B of this Agreement.

    For the current list of approved programs visit www.healthoptions.org.

5. EXCLUSIONS FROM BENEFITS

The Plan will not provide Benefits for: (1) anything that is not Medically Necessary; (2) anything provided before or after the effective date of coverage (except as required by law); (3) non-Covered Services and any services, items, or charges related to non-Covered Services; (4) services, supplies, and any charges from a non-Provider or an excluded Provider; (5) items and services (except for Emergency Services covered by the Plan) furnished outside the United States when you could have foreseen needing such care before leaving the U.S., including but not limited to childbirth or problems with pregnancy after the 37th week of pregnancy or after being told by a Provider you should not travel; and (6) services and supplies to the extent that you do not have to pay or you have the right to recover expenses through a federal, state, county, or local law (even if you waive or do not assert your rights).

The following list of services and supplies are not Covered Services and the Plan will not provide Benefits for them. These exclusions are in addition to other exclusions listed in this Agreement. If you pay for a non-Covered Service, it will not count toward your Out-of-Pocket Cost limits.

1. Acts of War. Benefits are not provided for any illness or injury that is a result of war, declared or undeclared, or any act of war.

2. Alternative and Complementary Treatment and Therapy. The Plan does not provide Benefits for alternative or complementary treatments and therapies for which clinical effectiveness has not been proven as determined by CHO's Chief Medical Officer. These include, but are not limited to:

   a. Acupuncture,
   b. Biofeedback,
   c. Holistic medicine,
   d. Homeopathy,
   e. Hypnosis,
   f. Aroma therapy,
   g. Reiki therapy,
   h. Massage therapy,
   i. Herbal, vitamin or dietary products or therapies,
   j. Naturopathy,
   k. Thermography,
   l. Orthomolecular therapy,
   m. Contact reflex analysis,
   n. Bioenergial synchronization technique, and
   o. Iridology.

   If you receive Covered Services from a licensed Provider of alternative or complementary treatment, and that Provider is operating within the scope of his or her license, those Covered Services will be covered according to your *Schedule of Benefits.*

3. Artificial Heart Devices. Artificial or mechanical hearts or heart assist devices are not covered as a Benefit. This exclusion does not include pacemakers or defibrillators. In addition, services and supplies for treatment of a heart condition while such devices remain

in place are also not covered. The only exception is for left ventricular assist devices that are being used temporarily while awaiting heart transplant.

4. Commercial Diet Plans and Programs. The Plan does not provide Benefits for commercial diet plans or weight loss programs except as specifically approved by CHO and covered under this Agreement.

   This exclusion does not apply to Medically Necessary treatments for morbid obesity. See section 4.B.47.

5. Cosmetic Services. Except for reconstructive services described under section 4.B.64, the Plan does not provide Benefits for Cosmetic Services.

6. Custodial Care. The Plan does not provide Benefits for services, supplies, or charges for Custodial Care, Domiciliary Care, or convalescent care.

7. Dental Care. Except as covered under section 4.B, the Plan does not provide Benefits for dental services, including but not limited to dental surgery, dental implants, or Orthognathic Surgery.

8. Drugs (Medications). Unless specifically stated otherwise in this Agreement, the Plan does not provide Benefits for the following:

   - Drugs that are not included on the formulary
   - Legend (prescription) drugs that are not deemed Medically Necessary
   - Experimental or Investigational drugs
   - Therapeutic devices or appliances
   - Anorectic or any other drugs used for the purpose of weight control
   - Any drug used for cosmetic purposes
   - Drugs filled without a prescription
   - Drugs related to infertility services
   - Drugs prescribed for impotence, erectile dysfunction, and/or sexual dysfunction
   - Prescription refills in excess of the number specified by the prescribing Provider
   - Prescription refills dispensed more than one year from the date of the original order
   - Any portion of a drug for which Prior Approval or step therapy is required but not obtained
   - Any drug obtained before the Member became covered under the Plan
   - Any drug obtained after the Member's coverage has ended
   - Any prescription drugs that are lost, stolen, spilled, spoiled, or damaged.

9. Durable Medical Equipment/Medical Supplies. The Plan does not provide Benefits for spare or back-up or other Durable Medical Equipment or Medical Supplies unless specifically stated. For a full list of excluded equipment and supplies, visit www.healthoptions.org or contact Member Services.

10. Erectile Dysfunction. The Plan does not provide Benefits for any drugs, supplies, services, or equipment for the treatment or correction of Erectile Dysfunction.

11. Experimental or Investigational Services. The Plan does not provide Benefits for any drugs, supplies, services, or equipment that are Experimental or Investigational as defined in this Agreement. The Plan does not provide Benefits for costs related to the provision of

Experimental or Investigational drugs, supplies, services, or equipment. These exclusions do not apply when coverage is required by law.

Statement for New Technology: CHO recognizes the need to evaluate coverage of new clinical technology by the CHO health plans. CHO reviews requests to evaluate new technologies from a variety of sources. If you would like a copy of CHO's procedures for reviewing new technology, please call Member Services at 1-855-624-6463.

12. Food or Dietary Supplements. The Plan does not provide Benefits for nutritional or dietary supplements unless covered in this Agreement or required by law. This exclusion includes, but is not limited to, over-the-counter nutritional formulas and dietary supplements.

13. Gender Reassignment (Sex Changes). The Plan does not provide Benefits for surgical services related to any gender reassignment (sex changes).

14. Government Services and Supplies. When services and supplies are provided by a facility owned or operated by federal, state, county, or local government, Benefits are not provided under the Plan. The Plan does not provide Benefits for services and supplies (1) provided by the U.S. Department of Veterans Affairs to veterans for a service-connected disability, or (2) provided by a uniformed services facility (unless you are a military dependent or retiree).

15. Gym or Spa Memberships. The Plan does not provide Benefits for health spas, gym memberships, health club memberships, exercise equipment, physical fitness or personal training, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Provider.

16. Hearing Care. The Plan does not provide Benefits for routine hearing examinations except for screening Members under the age of 19 years or when related to injury or disease and otherwise covered under this Agreement. Please see section 4.B.30 for Benefits for Hearing Aids.

17. Infertility; Surrogacy. The Plan does not provide Benefits for fertility drugs, Diagnostic Services, procedures, treatment, or other services or costs related to Infertility. This exclusion also applies to drugs used to enhance fertility.

    The Plan does not provide Benefits for services, supplies, or costs associated with surrogacy pregnancies. The Plan does not provide Benefits for the bearing of a child by another woman for an infertile couple. If the woman bearing the child is a CHO Member benefits will be applied according to the woman's Plan. .

18. Maintenance. The Plan does not provide Benefits for Maintenance Services, treatments, or therapy. This exclusion does not include habilitative therapy or Maintenance Medications.

19. Miscellaneous Expenses; Extra Services; Missed Appointments; Travel Costs.

    a. The Plan does not provide Benefits for Provider charges to provide required information to process a claim or application for coverage. The Plan does not provide Benefits for Appeal costs other than costs CHO must pay under law.

    b. The Plan does not provide Benefits for extra services from your Provider. These extra services are sometimes called "concierge services." These extra services may include:

        (i) Telephone access to your Provider 24 hours a day, 7 days a week;

(ii) Having a Provider accompany you to appointments with Specialists;

(iii)Guaranteed same-day appointments when not Medically Necessary; and

(iv) Making travel arrangements for you.

c. The Plan does not provide Benefits for fees you are charged for missed appointments.

d. The Plan does not provide Benefits for any travel costs, whether or not the travel is recommended by a Provider.

20. Occupational Therapy. The Plan does not provide Benefits for treatment such as massage therapy, paraffin baths, hot packs, whirlpools, or moist/dry heat applications unless in conjunction with an active course of treatment. Please see section 4.B.50.

21. Orthognathic Surgery. The Plan does not provide Benefits for Orthognathic Surgery, except as covered under section 4.B.64.

22. Orthotic Devices; Shoe Inserts. The Plan does not provide Benefits for Orthotic Devices except as covered in section 4.B.54. The Plan does not provide Benefits for shoe inserts except in certain cases for diabetic care.

23. Personal Comfort and Convenience. The Plan does not provide Benefits for any personal comfort or convenience items, including but not limited to television rentals, television service, newspapers, telephones, telephone service, or guest services.

24. Personal Enrichment. The Plan does not provide Benefits for any of the following services or any services relating to:

    a. Sensitivity training;
    b. Recreational or social programs;
    c. Sports camps and other camps;
    d. Life coaching;
    e. Encounter groups;
    f. Educational programs except those provided in this Agreement;
    g. Guidance and career counseling; or
    h. Relaxation activities.

25. Physical Therapy. The Plan does not provide Benefits for treatment such as massage therapy, paraffin baths, hot packs, whirlpools, or moist/dry heat applications unless in conjunction with an active course of treatment. Please see section 4.B.58.

26. Preventive Care. The Plan does not provide Benefits for preventive care and well-care services, unless otherwise stated in the "Covered Services" section 4.B.

27. Prostheses. The Plan does not provide Benefits for dental prostheses, or prosthetic devices to replace, in whole or in part, an arm or a leg, that are designed exclusively for athletic purposes. Please see section 4.B.62.

28. Refractive Eye Surgery. The Plan does not provide Benefits for refractive eye surgery, such as radial keratotomy or laser surgery, for vision conditions that can be corrected by glasses, contact lenses, or means other than surgery.

29. Relatives or Volunteers. The Plan does not provide Benefits for any services or supplies provided to you by immediate family members or step-family members. Services performed by volunteers are not covered, except as specifically provided in this Agreement.

30. Reversing Voluntarily Induced Sterility. The Plan does not provide Benefits for services to reverse voluntarily induced sterility.

31. Routine Foot Care. The Plan does not provide Benefits for routine foot care.

32. Speech Therapy. The Plan does not provide Benefits for any speech therapy for deficiencies resulting from intellectual disabilities or dysfunctions that are self-correcting, such as language treatment for young children with natural dysfluency or developmental articulation errors. Please see section 4.B.68.

33. Temporomandibular Joint Syndrome ("TMJ"). The Plan does not provide Benefits for services for the evaluation, diagnosis, or treatment of TMJ, whether medical or surgical.

34. Vision Care. The Plan does not provide Benefits for vision therapy, including treatment such as vision training, orthoptics, eye training, or eye exercises. No Benefits are provided for deluxe or designer glasses or frames.

    Except as provided under section 4.B, the Plan does not provide Benefits for the prescription, fitting, or purchase of glasses or contact lenses.

35. Workers' Compensation. The Plan does not provide Benefits for services, supplies, or equipment for work-related illness, injury or disability that is due to an occupational disease for those with coverage under the workers' compensation laws or other programs of similar nature. If CHO pays for services that are covered under workers' compensation, we reserve the right to recover payment from the Provider and/or the liable party.

    If, under State law, you are allowed to waive all workers' compensation coverage, this exclusion will not apply to the extent you waive workers' compensation coverage.

6. BENEFIT DETERMINATIONS, PAYMENT, AND CLAIMS

A. Benefit Determinations

The Plan, or a person or entity working on behalf of the Plan, will administer your Benefits and determine your Benefits in accordance with the terms of this Agreement. For Claim Denials, your Explanation of Benefits is your Notice of Adverse Benefit Determination. Other Adverse Benefit Determinations are described in section 2.H.4.

If you disagree with a determination made by the Plan, you may submit complaints and Appeal the decision as described in section 8.

B. Payment for Provider Services

1. Plan Providers

   If your claim from a Plan Provider is approved, the Plan will pay Benefits directly to the Plan Provider. Except for your Out-of-Pocket Costs, if applicable, you are not required to pay any balances to the Plan Provider until the Plan determines what it will pay.

   If you receive services from a Plan Provider that are not Covered Services, you will be responsible for the cost of those non-Covered Services. If a Plan Provider, who is licensed to perform alternative or complementary treatment and therapy, who is operating within the scope of his or her license and provides services that are listed as Covered Services, your cost-sharing responsibility is outlined in the *Schedule of Benefits.*

2. Non-Plan Providers

   If you receive Covered Services from a Non-Plan Provider, your cost-sharing will be higher, as described in the Out-of-Network portion of your *Schedule of Benefits*. If the Plan approves your claim for payment of services rendered by a Non-Plan Provider, the Plan will pay Benefits up to the Maximum Allowable Charge. We will pay Benefits directly to you or to the Non-Plan Provider.

   Charges above the Maximum Allowable Charge will not apply to your Out-of-Network cost-sharing and will be your responsibility, if the Non-Plan Provider chooses to bill you. This means you may have financial responsibility greater than the cost-sharing described on your *Schedule of Benefits*. This is sometimes called Balance Billing. Before you receive a service, you may call CHO toll-free at 1-855-624-6463 (TTY/TDD: 711) to learn the Maximum Allowable Charge for a service. If we deny your claim, you have the right to appeal our decision by following the steps in section 8. For Medical Emergency services rendered by a Non-Plan Provider, your Out-of-Pocket Costs will be the same as though you received care from a Plan Provider.

C. Out-of-Pocket Costs

1. Copayments and Coinsurance

   You may have some responsibility for the cost of Covered Services under this Agreement and the *Schedule of Benefits*. Your responsibility may come in the form of Copayments and Coinsurance. These should be paid directly to the Provider. If you have Coinsurance

responsibility, you will pay your Coinsurance percentage based on the Provider's discounted or negotiated charges with CHO, if any.

2. Deductible

   Members may be responsible for paying a yearly Deductible amount described in each Member's *Schedule of Benefits*. Each Calendar Year, before the Plan pays Benefits for many Covered Services, Members must pay the applicable Deductible. Expenses for non-Covered Services will not apply to the Deductible. Copayments do not apply to the Deductible.

   If you receive Covered Services during the last month of the Calendar Year and charges for these Covered Services are applied toward that year's Deductible, then these same charges will also be applied toward the Deductible for the following year.

   a. Family Deductible. Under family coverage, if the total family expenses for Covered Services exceed two times the individual Deductible, then your family Deductible under this Agreement has been met for the Calendar Year. In this case, you and your Dependents will be eligible for Benefits for the rest of the Calendar Year without having to pay further Deductibles.
   b. One Deductible for a Common Accident. Under family coverage, if two or more family members are injured in the same Accident, only one Deductible will apply for all Covered Services resulting from that Accident during a Calendar Year.

3. Out-of-Pocket Limits

   Member annual Out-of-Pocket Costs for Copayments, Coinsurance, and Deductibles may be limited. Please see the *Schedule of Benefits* for details on any Out-of-Pocket Cost limits.

4. Benefit Maximums

   Certain Covered Services may have maximum Benefits. Benefits that are "Essential Health Benefits" as described by the Patient Protection and Affordable Care Act may not have annual or lifetime dollar limits.

5. Plan Providers vs. Non-Plan Providers

   Please note that your Out-of-Pocket Costs for Covered Services may be higher when Covered Services are provided by a Non-Plan Provider, or "out-of-network." This difference is described in more detail in your *Schedule of Benefits*. Under Maine law, the difference between your Out-of-Pocket Costs for Covered Services provided by a Plan Provider and a Non-Plan Provider cannot be more than 20%. When you receive services for a Medical Emergency, your Out-of-Pocket Costs will be at the Plan Provider level whether you see a Plan Provider or a Non-Plan Provider.

6. Third-Party Payment of Out-of-Pocket Costs

   There may be instances where someone other than the Member pays the Member's Out-of-Pocket Costs under this Agreement. This is sometimes called "third-party payment of Out-of-Pocket Costs."

Members' family members, Designees, and legal representatives may pay Out-of-Pocket Costs on behalf of Members. Ryan White HIV/AIDS Programs, Indian tribes, tribal organizations, urban Indian organizations, and state and federal government programs may also pay Out-of-Pocket Costs on behalf of CHO Members.

A Member may not have a Provider, pharmaceutical company, or other commercial health care entity pay for Out-of-Pocket Costs on behalf of a Member.

D. Claims (Proof of Loss) Procedures

1. Claims Generally

Plan Providers will file claims directly with the Plan. Members may need to submit a claim for reimbursement for services from a Non-Plan Provider. If you need to submit a claim for a service, you or your Designee must do so within 120 days after the service is rendered. However, you may be allowed extra time if there is good reason why the claim cannot be submitted on time, and if you submit the claim as soon as you reasonably can.

Time Limits for Post-Service Claims: CHO must receive a claim within 120 days after receiving a service or item covered by the Plan or as soon as reasonably possible after the 120 days if it is not reasonably possible to submit notice within 120 days.

You may obtain a medical or prescription drug claim form at www.healthoptions.org or by calling Member Services at 1-855-624-6463 (TTY/TDD: 711). The form will include instructions on what information you will need to submit to the Plan so that the Plan can make a decision on the claim. Please return the completed claim form along with copies of any receipts or invoices to the address on the form.

If we do not furnish these forms to you within 15 days after we receive your request, you may meet the proof requirements by giving us a written statement of the nature and extent of the claim within 120 days after the service is rendered.

If you have paid a Provider for Covered Services and want the Plan to reimburse you directly, please send the receipts from the Provider to show proof of payment with your reimbursement form.

Benefits will be paid to the Member who received the services for which a claim is made unless the Member is a minor. In this case, Benefits will be paid to the parent or custodian with whom the minor resides. The Member may authorize CHO to pay Benefits directly to the Provider who charged for the service subject to the claim.

Any payment made by CHO in accordance with the terms of this Agreement will discharge CHO from all further liability to the extent of such payment.

2. Payment Limits

The Plan limits what it will pay for Covered Services not provided by a Plan Provider. The most the Plan will pay is the Maximum Allowable Charge. **You may have to pay the balance if the claim is for more than the Maximum Allowable Charge even if you have met your Out-of-Network Out-of-Pocket Maximum.** The Plan will pay Benefits within 30 days after receipt of the claim and proof supporting the claim.

7. OTHER COVERAGE

A. Other Insurance Coverage – Generally

If you receive services that are covered by the Plan and that are also covered by another payment source, your Benefits will be coordinated with the other payment source. This is called coordination of benefits ("COB"). Your Benefits may also be subject to something called "subrogation." Both of these items are explained below. The purpose of COB and subrogation is to prevent duplicate recovery for the same service. This section does not provide coverage for any service or supply that is not expressly covered under this Agreement, nor increase the level of coverage provided under this Agreement.

B. Coordination of Benefits

Benefits under this Agreement and the *Schedule of Benefits* will be coordinated to the extent permitted by law with other types of insurance coverage that pay for health care services and supplies. These other types of coverage may include:

- Auto insurance;
- Homeowners' insurance;
- Government benefits;
- Medicare; and
- Health plans ("Health Plans"), including, group and non-group health insurance contracts, health maintenance organization plans, nonprofit medical or hospital service corporation plans, and self-insured plans.

When there is COB, it will be based upon the Maximum Allowable Charge for any service that is covered at least in part by any of the plans involved. If benefits are provided in the form of services, or if a Provider is paid under a capitation arrangement, COB will be based on the reasonable value of such services.

When a Member is covered by more than one Health Plan, one plan will be considered primary. The primary plan pays benefits first as though there was no other coverage. The benefits of secondary and tertiary plan(s) are determined after those of the primary plan and may be reduced by the amount allowed by the primary plan's benefits. To the extent required by law, when a Member is covered by more than one Health Plan, payments made by the primary plan, payments made by the Member, and payments made from a health savings account or similar fund for benefits covered under the secondary plan will be credited toward the deductible of the secondary plan.

1. <u>COB Rules for Health Plans</u>

   CHO follows the guidelines established by the National Association of Insurance Commissioners (NAIC) in determine primacy between two or more health plans. If both this Agreement and the other Health Plan(s) contains a COB clause allowing the COB with this Agreement, CHO will determine benefit payments by using the first of the following rules that applies:

   a. <u>Non-Dependent/Dependent</u>: The benefits of the contract that covers the person as an employee or subscriber will be primary before the benefits of the contract that covers the person as a dependent.

b. Dependent Children with Parents Not Legally Separated or Divorced: Where both parents carry insurance, the child's primary coverage is determined according to the birth date rule if both carriers apply it. The birth date rule states that the plan covering the biological parent with the earliest birth date (month and day) in the calendar year is primary. If parents share the same birthday, the plan that has covered the parent longest is the primary plan. If the other contract does not include the rule described immediately above, but instead has a rule based on the gender of the parent, and as a result the contracts do not agree on the order of benefits, the rule in this Agreement will determine the order of benefits.

c. Dependent Children with Parents Legally Separated or Divorced: Where a child has parents who are divorced or legally separated, coverage for children is determined first by the divorce decree stating who is responsible for health care coverage. If the parent with responsibility has no health care coverage for the dependent child but that parent's spouse does, that parent's spouse's plan is the primary plan. This item does not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree. If coverage is not ordered in the divorce decree, then the parent with legal custody is primary. If both parents are responsible for the health care coverage and neither parent has primary custody, then the birth date rule is applied.

d. Primacy for Dependent Child of Non Parent: For a dependent child covered under more than one plan of individuals who are not the parents of the child, primacy is determined by the Birth Date Rule, and Primacy for Children of Divorce, as applicable, as if those individuals were parents of the child. For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the Length of Coverage Rule applies and the plan that covered the person for the longer period of time is the primary plan.

e. Active/Inactive Employee: The Benefits of a contract that covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a contract that covers the person as a laid-off or retired employee (or as that employee's dependent). If the other Health Plan does not include this provision, and as a result, the contracts do not agree on the order of benefits, rule (f) below applies.

f. COBRA or Continuation of Coverage: If a person whose coverage is provided under the right of continuation pursuant to COBRA or another Federal or State law is also covered by another contract, the Benefits of the contract covering the person as an employee, Member, or Subscriber, or as the Dependent of an employee, Member, or Subscriber, will be primary. The Benefits of the continuation coverage will be secondary. If the other contract does not include this provision regarding continuation coverage, rule (f) below applies.

g. Length of Coverage Rule: If none of the above rules determines the order of Benefits, the Benefits of the contract that has covered the employee or Subscriber longer will be determined before those of the contract that has covered the person for a shorter period.

h. Unable to determine order of benefits: If none of the preceding rules successfully determines the order of benefits, the CHO allowable expenses shall be shared equally between the plans.

With respect to COB, CHO may exercise its rights to carry out COB without providing notice to, or obtaining consent from, Members. CHO may share information with another insurance company or party to determine COB and take steps to recover the Plan's excess payment from another party or pay another party for its excess payment. CHO reserves the right to suspend payment on a claim when the Plan is secondary until the Provider has submitted the claim to the primary plan and the primary plan has either paid or denied the claim. Nothing in this Agreement shall be interpreted to limit CHO's right to use any remedy provided by law to enforce CHO's rights to COB under this Agreement.

1. COB for Workers' Compensation, Government Benefits, and Other Insurance Coverage

   If CHO pays Benefits for services for an illness or injury covered under workers' compensation or a similar program, or a government benefit, to the extent allowed by law CHO may recover its expenses from Providers CHO pays or from one or more third parties.

   For Members who are entitled to benefits under the medical payment benefit of another insurance policy (e.g., auto, homeowners'), that policy will be responsible for coverage with respect to a covered loss under that policy. All payments for services provided by the Plan to Members that are covered under any such medical payment policy or benefit are payable to CHO.

2. Medicare

   If you are eligible for Medicare Part A, you must contact Member Services and let us know. You may remain an enrolled Member under the Plan even if you are enrolled in Medicare. To the extent allowed by law, your Benefits under the Plan will not duplicate any benefits that you receive under Medicare Part A or Part B regardless of whether you actually exercise your rights to Medicare Part A or Part B.

C. Subrogation

When a third party is legally responsible for your injury or illness, you may be entitled to payment from a claim or legal action against that party. When we provide Benefits for treatment of such injury or illness, we have the right to recover, on a just or equitable basis, from any such payment (whether or not such payment is for medical expenses) up to 100% of the Benefit we paid. We also have subrogation rights against your other insurance coverage, including medical payments, uninsured, and underinsured motorist provisions in your auto insurance policy. We reserve the right to recover from a Member up to 100% of the value of Benefits, on a just and equitable basis, provided or paid for by the Plan when a Member has been, or could have been, reimbursed for the cost of care by a third party. If the services related to your illness or injury are covered by a capitation fee, we are entitled to the reasonable cash value of the services. Nothing in this Agreement shall be interpreted to limit CHO's right to use any remedy provided by law to enforce CHO's rights to subrogation under this Agreement. Before we will enforce our subrogation rights, we will first obtain your prior written approval.

D. Cooperating with CHO

As a Member under the Plan, you agree to cooperate with us in exercising our rights of subrogation and COB under this Agreement. CHO agrees that subrogation payments will be made on a just and equitable basis. Your cooperation may include:

- Telling us when there is a possible legal action or claim that may implicate CHO's subrogation or COB rights;
- Giving us information and documents that we request;
- Assigning to CHO payments that you receive for services paid by CHO;
- Signing documents deemed necessary by CHO to protect its subrogation and COB rights, including, but not limited to, providing CHO with your prior written approval of CHO enforcing its subrogation rights; and
- Not taking any action that would impede CHO's subrogation or COB rights.

If you do not cooperate with CHO as provided in this section, you may be liable to CHO if CHO needs to enforce its rights. You may also be liable for CHO's costs and reasonable legal fees.

8. APPEALS AND COMPLAINTS

A. Contacting CHO's Member Services

CHO's Member Services Associates are available to assist Members in the resolution of complaints. If you have a complaint about a claim denial, we recommend that you contact a Member Services Associate before filing an Appeal. Sometimes, a claim denial is caused by a minor error or problem that can be resolved by a Member Services Associate without having to go through the Appeal process.

You may call to make a complaint to Member Services at 1-855-624-6463 (TTY/TDD: 711). You can also make a written complaint by mailing or faxing it to:

Community Health Options
Attn: Member Services
Mail Stop 100
P.O. Box 1121
Lewiston, ME 04243
Fax: 207-402-3745

After we receive your complaint, a Member Services Associate will look into and respond to your complaint. If you disagree with our response, you may be able to file an Appeal of the decision. Please contact Member Services if you have questions.

B. CHO's Appeal Process

This section describes CHO's internal Appeal process. If you receive an Adverse Benefit Determination, Adverse Health Care Treatment Decision, or Adverse Benefit Determination not involving a Health Care Treatment Decision, you may file an Appeal. Your Appeal will be decided by one or more persons not involved in making the decision that you are appealing. You may have a Designee or your Provider assist you with your Appeal. Please follow the steps described below.

Members who are visually and/or hearing impaired may request complaint and Appeal process materials in an appropriately accessible format by contacting CHO Member Services at 1-855-624-6463 (TTY/TDD: 711).

1. Provider Request for Reconsideration.

   A Provider may submit a request for reconsideration of claims paid on a Member's behalf. Provider requests for reconsideration are not considered Member Appeals. In the event that the reconsideration is adverse to the Member, the Member will maintain first- and second-level appeal rights.

2. Beginning Your Appeal

   To begin your Appeal, please contact Member Services by mail, phone call, or fax. You will need to give us specific information about your Appeal, including:

   a. Which decision(s) you are appealing;
   b. Why you disagree with the decision(s); and
   c. What you would like the outcome to be.

We may need to review your medical records, billing statements, and other documents to decide your Appeal. If we need more information (such as medical records, bills, or other documents) to process your Appeal, your Appeals Coordinator will let you know.

If you wish to appeal an Adverse Benefit Determination, Adverse Health Care Treatment Decision, or Adverse Benefit Determination not involving a Health Care Treatment Decision, you must submit your Appeal to CHO within 180 days from the date of the decision you wish to appeal. If you do not submit an Appeal within this time limit, you will lose your right to appeal the decision unless the delay is reasonable under the circumstances and does not negatively prejudice CHO's rights.

Please send your Appeal to:

Community Health Options
Attn: Appeals Coordinator
Mail Stop 100
P.O. Box 1121
Lewiston, ME 04243
Telephone: 1-855-624-6463 (TTY/TDD: 711)
Fax: 207-402-3745

After we receive your Appeal, we will assign an Appeals Coordinator to manage your Appeal throughout the entire appeal process. We will send you a letter identifying your Appeals Coordinator within three business days after we receive your Appeal. The letter will describe the appeal process and your rights in more detail. Please contact your Appeals Coordinator if you have questions.

Your appeal rights include:

a. Being allowed to review the claim file and to present evidence and testimony as part of the appeals process;
b. Being given, free of charge, any new or additional evidence considered, relied upon, or generated by CHO (or at the direction of CHO) in connection with the claim, unless the evidence is confidential or privileged. CHO will give you the evidence as soon as possible and with enough time in advance of the decision to give you a reasonable opportunity to respond;
c. Before CHO can issue a final adverse determination based on a new or additional reason, being provided with the reason, free of charge, with enough time in advance of the decision to give you a reasonable opportunity to respond; and
d. Receiving a notice from CHO describing your appeal rights within three business days after CHO receives your Appeal.

3. First Level Appeal Process

The first level appeal process involves either "standard review" or "expedited review."

Your Appeal will be eligible for an expedited review if your Appeal involves services that, if delayed, could seriously jeopardize your health or your ability to regain maximum function. We will grant an expedited review of any Appeal for services concerning (1) an Inpatient admission, (2) availability of care, or (3) continued health care or services for a Member who has received Medical Emergency services and has not been discharged from the Hospital where Medical Emergency services were provided. You, your Designee, or your Provider may request an expedited review.

a. Standard Review. Your Appeals Coordinator will investigate your Appeal. If your Appeal involves a medical determination, an appropriate clinical reviewer will review your Appeal. The assignedn Appeal reviewer shall not have been involved in the initial adverse determination and shall not be a subordinate of any individual involved in the initial adverse determination, unless the Appeal presents additional information the decision maker was unaware of at the time rendering the initial adverse health care treatment decision. The clinical peer may not be a subordinate of a clinical peer involved in the prior decision.

   After we receive all the information needed to make a decision, your Appeals Coordinator will notify you and your Provider in writing whether we have approved or denied your first level Appeal. We are able to make decisions in most first level Appeals within 20 business days after we receive the Appeal request. If we cannot reasonably meet the 20 business-day time frame due to an inability to obtain necessary information from a Non-Plan Provider, we will let you and your Provider know that we are requesting more time and why we need more time. We will make the decision on your first level Appeal and notify you within 20 business days after receiving all necessary information, unless you voluntarily agree to extend the time frame beyond this.

b. Expedited Review. An appropriate clinical reviewer, not involved in the initial adverse determination or a subordinate of any individual involved in the initial adverse determination, will investigate and complete expedited review of first level Appeals within 72 hours after we receive your Appeal. We will make a decision sooner if we can. It is critical that you provide all necessary information so that we can complete the expedited review quickly. For expedited Appeals involving (1) continued Medical Emergency services to screen or Stabilize a Member, or (2) continued care under an authorized admission or course of treatment, coverage will be continued without liability to the Member until the Member has been notified of the expedited appeal decision. We may call you and your Provider to tell you our expedited appeal decision. We will also send our written decision to you and your Provider within two business days after calling you.

c. Denial of First Level Appeal. We will notify you of our first level appeal decision. If we deny your first level Appeal, we will give you a written decision, which will include:

   (i) The reason(s) for the decision;

   (ii) Who made the decision;

   (iii) Reference to the specific Agreement provisions, other documents, and evidence used to make the decision;

   (iv) A description of any additional material or information necessary for the covered person to perfect the claim and an explanation as to why such material is necessary;

   (v) How you can obtain free copies of information relevant to the decision;

   (vi) Notice of your right to contact the Maine Bureau of Insurance by telephone at **1-800-300-5000** (within Maine) or **1-207-624-8475** (outside Maine) or by mail at 34 State House Station, Augusta, ME 04333;

   (vii) How to obtain a second level review;

   (viii) How to obtain an independent external review; and

(ix) How to contact the ombudsman, Consumers for Affordable Health Care, by telephone at **1-800-965-7476** or by mail at P.O. Box 2490, Augusta, ME 04338-2490.

4. Second Level Appeal Process (Voluntary)

If you disagree with the decision of the first level appeal process, you may request a second level Appeal. Your second level Appeal will be reviewed by a CHO review panel. CHO shall appoint a panel for each second level appeal, which shall include one or more reviewers not involved in the previous adverse determinations. If your Appeal involves a medical determination, the panel will include one or more clinical peers not involved in previous adverse determinations. A second level appeal decision involving a medical determination adverse to the Member must have the concurrence of a majority of the clinical peers on the panel. You must make a second level Appeal within 180 days after the date of the first level appeal decision. If you do not submit a second level Appeal within this time, you will lose your right to a second level Appeal unless the delay is reasonable under the circumstances and does not negatively prejudice CHO's rights.

You may waive your right to the second level appeal process and request an independent external review as provided below.

You have a right to attend the meeting to present your case to the review panel. You or your Designee must tell your Appeals Coordinator if you wish to attend. You may also participate in the meeting by telephone or video conferencing if you wish – please let your Appeals Coordinator know.

You may submit supporting materials both before and at the review meeting and you may ask questions of CHO representatives. You also may bring someone with you or be represented by someone, including a lawyer, at the review meeting. You also have the right to obtain free of charge from CHO your medical case and information relevant to your Appeal that is not confidential or privileged.

If you request to participate in the review panel, we will hold a review meeting within 45 days after we receive your request for a second level Appeal. You will be notified in writing at least 15 days in advance of the review meeting. We will let you know if CHO will have a lawyer presenting CHO's case. If you need to postpone the review meeting, please let your Appeals Coordinator know. The decision of the review panel will be sent to you in writing within five business days after a review meeting.

If you do not request to participate in the review panel, you will be provided with a written response to your second level Appeal within 30 calendar days after we receive your request for a second level Appeal.

If we deny your second level Appeal, we will give you a written decision, which will include:

(i) The reason(s) for the decision;

(ii) Who made the decision;

(iii) Reference to the specific Agreement provisions, other documents, and evidence used to make the decision;

(iv) A description of any additional material or information necessary for the covered person to perfect the claim and an explanation as to why such material is necessary;

(v) How you can obtain free copies of information relevant to the decision;

(vi) Notice of your right to contact the Maine Bureau of Insurance by telephone at **1-800-300-5000** (within Maine) or **1-207-624-8475** (outside Maine) or by mail at 34 State House Station, Augusta, ME 04333;

(vii) How to obtain an independent external review; and

(viii) How to contact the ombudsman, Consumers for Affordable Health Care, by telephone at **1-800-965-7476** or by mail at P.O. Box 2490, Augusta, ME 04338-2490.

5. Independent External Review

Appeal decisions involving an Adverse Utilization Determination or an Adverse Health Care Treatment Decision by CHO are eligible for review by an independent review organization designated by the Maine Bureau of Insurance. Adverse Utilization Determinations for purposes of independent external review include Medical Necessity, appropriateness, health care setting, level of care, effectiveness of a covered Benefit, Experimental or Investigational treatment or services, and rescission.

The external review decision must be made within 30 days after the independent review organization receives the request for the review. However, the decision must be made within 72 hours if delay would seriously jeopardize the life or health of the Member or would jeopardize the Member's ability to regain maximum function.

If the independent review organization decides in your favor, the decision is binding on CHO.

Normally, you must first complete CHO's first and second level appeals process to be eligible for independent external review. However, you are not required to complete the first and second level appeals process if:

a. CHO has failed to make a decision on your first or second level Appeal in the time frames noted above;
b. CHO has not followed all the federal and state requirements applicable to CHO's internal appeal process;
c. You have applied for expedited external review at the same time as applying for an expedited internal Appeal;
d. You and CHO mutually agree to bypass the CHO appeals process, or with respect to a second level Appeal you waive your right to a second level Appeal;
e. Your life or health is in serious jeopardy;
f. The Member for whom external review is requested has died; or
g. The Adverse Utilization Determination or Adverse Health Care Treatment Decision concerns an admission, availability of care, a continued stay, or health care services when the Member has received Medical Emergency services but has not been discharged from the facility that provided the Medical Emergency services.

You may obtain review under this section even though you have failed to obtain Prior Approval prior to receiving a Covered Service.

You must request external review by making your request in writing to the Maine Bureau of Insurance at 34 State House Station, Augusta, ME 04333. You must also make your request within 12 months after CHO's final denial of Benefits under our internal appeals process. You will not be charged a fee to initiate external review. You may have someone else make this written request for you if this person:

a. Has your written consent to make the request;
b. Is authorized by law to make the request on your behalf; or
c. Is your family member or treating Provider, but only if you are unable to make the request.

6. Second Opinions.

In any Appeal in which a professional medical opinion regarding a health condition is a material issue in the dispute, you may be entitled to an independent second opinion from a Provider of the same specialty, paid for by the Plan.

C. Complaints

If you have any complaints about CHO's services or your Plan, please contact Member Services:

Community Health Options
Attn: Member Services Department
Mail Stop 100
P.O. Box 1121
Lewiston, ME 04243
Telephone: 1-855-624-6463 (TTY/TDD: 711)
Fax: 207-402-3745

CHO will respond to you as quickly as we can. Most complaints can be investigated and responded to within 30 days.

You may also submit complaints to the Maine Bureau of Insurance:

Maine Bureau of Insurance
34 State House Station
Augusta, ME 04333
Telephone: 1-800-300-5000 (within Maine) or 1-207-624-8475 (outside Maine)

D. Legal Action against CHO

A Member may only bring legal action against CHO for an Adverse Utilization Determination or Adverse Health Care Treatment Decision if the Member or the Member's representative has exhausted the complaint and appeals process outlined in section 8. A Member must bring this type of legal action within 3 years from the earlier of: (1) the date of issuance of the written external review decision, or (2) the date of issuance of the underlying adverse first level appeal decision.

No action at law or in equity shall be brought to recover on this Agreement prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Agreement. No such action shall be brought after the expiration of three years after the time in which written proof of loss is required to be furnished.

9. RENEWABILITY AND TERMINATION

This Agreement and your coverage will be in effect until terminated as provided by this Agreement, as applicable, and by Federally Facilitated Marketplace (FFM) requirements, as applicable. Once your Agreement terminates, the Plan will not provide Benefits for Covered Services rendered after the effective date of termination. CHO or the FFM will notify you of when your coverage terminates.

A. Renewability

This Agreement will renew as required under state and federal law. The Agreement will be renewed when the Premium is timely paid by the end of the applicable grace period. CHO may not renew this Agreement for nonpayment of Premiums, fraud or intentional misrepresentation of material fact, the Plan terminates as allowed under state and federal law, the Subscriber fails to reside in the service area of the Plan, or CHO stops offering coverage in the service area.

B. Termination by Member

A Subscriber may request that we end this Agreement and coverage under the Plan at any time by sending a signed, written statement to CHO. This Agreement and the Member's coverage will be terminated effective the last day of the month in which CHO receives written notice or the last day of a future month as requested by the Member. If the Member receives coverage under the Plan through the Federally Facilitated Marketplace and the Member becomes eligible for coverage under Medicaid, the Children's Health Insurance Program, or a Basic Health Program, the termination will be effective the day before new coverage starts.

Coverage under the Plan received through the FFM must be canceled by contacting the FFM in addition to providing written notice to CHO.

CHO will refund to the Member Premiums paid for periods after the effective date of termination.

C. Termination by CHO

CHO may terminate this Agreement and coverage under the Plan as follows:

1. CHO will give thirty days' notice of termination for:

    a. Failure to meet all of the eligibility requirements for coverage under the Plan and imposed by the FFM, as applicable;
    b. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact. In addition, CHO may rescind this Agreement and coverage as provided in section 9.D; and
    c. Non-payment of Premium as provided in section 3.D.

2. CHO will give 90 days' notice of termination of the Plan if:

    a. The Plan is no longer offered in the service area or CHO ceases offering any coverage in the service area as permitted by state and federal law; or
    b. The Plan is terminated or no longer certified by the FFM.

3. If the Member switches coverage, CHO will give notice of termination as required by Federal law.

CHO will refund to the Member Premiums paid for periods after the effective date of termination.

D. Rescission

CHO reserves the right to rescind a Member's coverage as of the last date of eligibility for any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by the Member. Any claims incurred after the date of eligibility for which CHO is unable to recover payment from the Provider will be the responsibility of the Subscriber.

E. Notice of Termination

A Member has the right to designate a third party to receive notice of termination of this Agreement, and to change the person designated to receive such notice, by completing and sending to CHO a Third Party Notice Request form. Please contact Member Services at 1-855-624-6463 (TTY/TDD: 711) to make or change such designation. CHO will send a Third Party Notice Request form within 10 days of the request.

F. Right to Reinstatement

1. <u>Cognitive impairment or functional incapacity</u>

   Under Maine law, a Member may be eligible to reinstate the Agreement within 90 days after the termination if non-payment of Premium or other lapse or default took place because you suffered from cognitive impairment or functional incapacity at the time of termination. You, someone authorized to act on your behalf, or a Dependent may request reinstatement.

   We may require you prove that you suffered from cognitive impairment or functional incapacity at the time of termination. This proof may include getting a medical examination at your own expense or giving us medical records. If you qualify for reinstatement under this section, we will reinstate your coverage without a break in coverage. We will reinstate your coverage as though it had not been terminated. Your reinstated coverage will be subject to the same terms, conditions, exclusions, and limitations.

   Before your coverage is reinstated, you must pay the amount due from the date of termination through the month in which we bill you within 15 days after we request that you make payment. If you do not pay in time, we are not required to reinstate your coverage and you will be responsible for claims incurred after the effective date of termination.

   If we deny your request for reinstatement, we will send a notice to you and to the person who made the request, if different. You have the right to an Appeal under section 8, or to request a hearing before the Maine Bureau of Insurance, within 30 days after you receive the notice from us.

Notice of cancellation will be provided to you and your designated third party at least 10 calendar days before cancellation of this Agreement. Such notice shall include the reason(s) for cancellation, amount of unpaid Premium and the date by which the Premium must be paid, if applicable, and notice of the right to guaranteed issuance of individual health plans.

2. Acceptance of Premium

If coverage under this Agreement terminates due to non-payment of Premium, we require an application for reinstatement. We will advise you of the effective date of reinstatement by giving you written notice of the date. In any case, the reinstated coverage provides Benefits only for:

a. Injury occurring after the effective date of reinstatement; and
b. A condition first manifesting itself more than 10 days after the effective date of reinstatement.

10. OTHER PROVISIONS

A. Assignment of Benefits

You may assign Benefits provided for Covered Services only to the Provider rendering services. You may not assign this Agreement to anyone else without our written permission.

B. Entire Agreement

This Agreement, the *Schedule of Benefits*, and any *Application* make up the entire agreement between you and CHO with respect to the subject matter contained in these documents.

C. Changes to this Agreement

This Agreement and the *Schedule of Benefits* may be amended by CHO upon sixty (60) days' written notice to you. Amendments do not require the consent of Members. Amendments can only be made in writing by an authorized officer of CHO. No agent has authority to change this Agreement or waive any of its provisions.

Rates are guaranteed for the 12-month rating period. We will notify you at least 60 days before an increase in Premium.

D. Non-enforcement

If CHO does not enforce compliance with any provision of this Agreement, this non-enforcement shall not be deemed to be a waiver by CHO of that provision or any other provision of this Agreement.

E. Relationship between CHO and Providers

CHO has separate contracts with Plan Providers. Plan Providers are independent contractors. They are not agents or employees of CHO. Plan Providers may not modify this Agreement or the *Schedule of Benefits*. Only CHO may modify this Agreement as provided under section 10.C. Plan Providers cannot make binding promises on behalf of CHO.

CHO may change its arrangements with Plan Providers, including addition and removal of Plan Providers. CHO will try to give you at least 60 days' notice before CHO removes a Plan Provider. If it is impossible for CHO to give you this much notice, CHO will give you as much notice as possible.

CHO does not render health care services, supplies, or equipment to Members. Instead, CHO arranges Covered Services for Members and pays Benefits in accordance with this Agreement. It is Providers who render health care services, supplies, and equipment to Members. CHO does not interfere with the independent medical judgment of Providers.

F. Relationship between CHO and the Federally Facilitated Marketplace

CHO and the FFM are two separate entities. Statements made by the FFM call center representatives do not represent CHO and cannot be relied upon for binding promises on behalf of CHO. CHO is not responsible for incorrect or misleading information given by a FFM call center representative.

G. Notice

Any notice to a Member will be sent to the last address of the Member on file with CHO.

Notices to CHO should be sent to:

Community Health Options
Attn: Member Services
Mail Stop 100
P.O. Box 1121
Lewiston, ME 04243

H. Disasters

In the event of a war, riot, epidemic, or other major disaster (natural or manmade) (together, "Disasters"), CHO will try to arrange for services. CHO is not responsible for the costs or outcome of its inability to arrange for services due to a Disaster.

I. Confidentiality of Member Information

CHO is committed to ensuring and safeguarding the confidentiality of its Members' personal and medical information. We are subject to various federal and state laws regarding how we access, use, and disclose Member information. We will access, use, and disclose the minimum information necessary to accomplish the purpose of the task. We will only access, use, and disclose your information as allowed by law or obtain your specific permission to access, use, or disclose your information.

Examples of when we will need to access, use, and disclose Member information include:

1. Obtaining and sharing information with your Providers so we can perform Prior Approval activities;
2. Conducting quality activities;
3. Obtaining information from Providers so we can properly pay Benefits; and
4. When we are required or authorized by law to access, use, or disclose information.

CHO sometimes contracts with other persons and entities to perform tasks on behalf of CHO. CHO requires these other persons and entities to comply with CHO's policies on protecting Member information and applicable state and federal laws.

There may be times when CHO needs your (or your Designee's) written authorization to disclose your information. This may be true even if you request that we disclose your information. In cases where we need written authorization, we will provide a copy of our written authorization form to you (or your Designee) to complete and sign.

We will protect your Protected Health Information as required by the Health Information Portability and Accountability Act (HIPAA). For more details on how we will handle your Protected Health Information, please see our Notice of Privacy Practices.

J. Providing CHO with Information

The Member agrees that CHO may have access to (1) all health records and medical data from Providers rendering care to Members, and (2) information about other types of insurance, such as auto insurance, Health Plans, and homeowners' insurance, and other sources of payment for COB purposes. Sometimes, your Providers or other insurers may need your (or your Designee's) written authorization to disclose information to us. Please ask your Providers or other insurers about how to do this.

K. Time Limit on Certain Defenses

After 3 years from the date of this Agreement, no misstatements, except fraudulent misstatements, made by the Member in the *Application* for this Agreement shall be used to void the Agreement or to deny a claim.

L. Physical Examination; Autopsy

We have the right and opportunity, at our own expense, to examine the Member when and as often as it may be reasonably required during the pendency of a claim hereunder and to make an autopsy in the case of death, unless forbidden by law.

M. Conformity with State Statutes

Any provision of this Agreement that, on its effective date is in conflict with the statutes of the State of Maine, is hereby amended to conform to the minimum requirements of such statutes.

N. Subcontractors

CHO may subcontract with individuals and entities to provide services on behalf of CHO. Subcontractors may include, but are not limited to, prescription drug benefit managers and behavioral health managers. Subcontracted duties may include Benefit determinations, paying claims, administrative services, or other duties.

O. Genetic Information

CHO will not discriminate on the basis of genetic information as provided in the federal Genetic Information Nondiscrimination Act of 2008.

11. GLOSSARY

Accidental Injury. Accidental bodily injury sustained by a Member that is the direct cause of the condition for which Benefits are provided and that occurs while this Agreement is in force.

Advance Payments of Premium Tax Credit or Tax Credit. The federal tax credit available to eligible persons who apply for private insurance coverage through the Federally Facilitated Marketplace to help offset the costs of monthly Premiums.

Adverse Benefit Determination. By or on behalf of CHO, any (1) Adverse Health Care Treatment Decision, or (2) denial reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit, including an action based on a determination of a Member's ineligibility to participate in the Plan.

Adverse Health Care Treatment Decision. A health care treatment decision made by or on behalf of CHO denying in whole or in part payment for or provision of otherwise Covered Services requested by or on behalf of a Member. Adverse Health Care Treatment Decisions include rescission determinations and initial coverage eligibility determinations as provided under federal law.

Adverse Utilization Determination. A determination by CHO that: (1) an admission, availability of care, continued stay, or other health care service has been reviewed and does not meet CHO's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness; and (2) payment for the requested services is therefore denied, reduced without further opportunity for additional service, or terminated.

Ambulatory Surgery Center. A facility that is licensed by a state or certified by Medicare as an ambulatory surgery center.

Amendment. An addition, deletion, or revision to the terms and conditions of this Agreement.

Appeal. A request by a Member or the Member's Designee to have CHO review a decision as described in section 8 of this Agreement.

Appeals Coordinator. The individual who manages a Member's Appeal throughout the entire appeal process.

Application. CHO or FFM application submitted for the purpose of securing health insurance from CHO.

Applied Behavior Analysis. The design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

Balance Billing. When a Provider bills a Member for some or all of the remaining charges not paid by the Plan (this does not include Member Out-of-Pocket Costs).

Basic Health Program. A program under the Patient Protection and Affordable Care Act that allows states to offer subsidized coverage for certain individuals with low incomes. Not all states offer a Basic Health Program.

Benefits. Payments we make on your behalf under this Agreement and your coverage under the Plan.

Calendar Year. When your coverage first begins under the Plan, the Calendar Year is the effective date of your coverage through the earlier of (1) December 31 in the year your coverage first begins, or (2) the date your coverage ends due to termination as defined in section 9. For years after the year in which your coverage first begins under the Plan, the Calendar Year is January 1 through the earlier of (1) the first occurring December 31, or (2) the date your coverage under the Plan ends.

Children's Health Insurance Program ("CHIP"). CHIP is a federal and state program that provides low-cost health insurance coverage for children in families who earn too much income to qualify for Medicaid coverage but can't afford to purchase private health insurance.

Chiropractor or Doctor of Chiropractic. A person who is licensed to perform chiropractic services.

Coinsurance. The percentage paid by a Member toward the cost of the Maximum Allowable Charge of some Covered Services.

Community Mental Health Center. An institution that is licensed as a comprehensive community mental health center.

Copayment. Fees payable by Members for certain Covered Services. Copayments are payable at the time of the visit or when billed by the Provider.

Cosmetic Services. Medical and surgical services intended solely for the purpose of changing or improving appearance.

Covered Services. Services, supplies, or treatment covered by this Agreement and as described in section 4.B.

Custodial Care. Services that are (1) not for the primary purpose of treating an illness or injury or primarily intended to help a patient gain materially improved functioning within a reasonable timeframe established in a plan of care, and (2) for the purpose of assisting with activities of daily living. Such services include, but are not limited to, help with: personal hygiene, bathing, dressing, skin and nail care, toileting, preparing meals and feeding, walking or transferring positions, giving medicines that are typically self-administered, and catheter care. Services may be Custodial Care regardless of whether such services are performed or ordered by a Provider and regardless of where the services are performed.

Day Treatment Program. Mental health or substance abuse services on an individual or group basis for more than two hours, but less than 24 hours a day, in a Hospital, mental health center, Substance Abuse Treatment Facility, or Community Mental Health Center.

Deductible. If your Plan has a Deductible requirement, the Deductible is the amount you are required to pay for Covered Services each Calendar Year before the Plan begins to pay Benefits.

Dental Service. Items and services provided in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth.

Dependent. A member of the Subscriber's family who meets the eligibility requirements to be a Dependent under this Agreement.

Designee. Someone who is 18 years of age or older whom you designate to act on your behalf.

Diagnostic Service. A service performed to diagnose specific signs or symptoms of an illness or injury, such as: x-ray exams (other than teeth), laboratory tests, cardiographic tests, pathology services, radioisotope scanning, ultrasonic scanning, and certain other methods of diagnosing medical problems.

Domiciliary Care. Services (including therapeutic services) and room and board provided in a hotel, health resort, home for the aged, residential facility, treatment center, halfway house, or educational institution because a Member's own living arrangements are inadequate or unavailable.

Durable Medical Equipment. Equipment that meets all of the following criteria:

1. Can withstand repeated use;
2. Is used only to serve a medical purpose;
3. Is appropriate for use in the patient's home;
4. Is not useful in the absence of illness, injury or disease; and
5. Is prescribed by a Physician.

Durable Medical Equipment does not include fixtures installed in your home or installed on your property.

Early Intervention Services. Services provided by licensed occupational therapists, physical therapists, speech-language pathologists or clinical social workers working with children from birth to 36 months of age with an identified developmental disability or delay as described in the federal Individuals with Disabilities Education Act.

Emergency Services. Those health care services that are provided in an emergency facility or setting after the onset of an illness or medical condition that manifests itself by symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected by the prudent layperson, who possesses an average knowledge of health and medicine, to result in:

1. placing the enrollee's physical and/or mental health in serious jeopardy;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

Experimental or Investigational. Procedures, treatments, services, equipment, supplies, devices, drugs, medications, and biologics that CHO determines to be experimental or investigational for the purposes of diagnosis or treatment of an illness or injury. CHO makes these determinations based upon criteria adopted by CHO and as required by federal law. The following are examples of Experimental or Investigational items:

1. Drugs classified by the FDA as treatment investigational new drugs;
2. Services involved in clinical trials;
3. Devices that have an FDA investigational device exemption; and
4. Devices for which the FDA has limited access or approval.

Federally Facilitated Marketplace. A mechanism intended to provide a transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans.

Federally Qualified Health Center. A facility that is designated as a federally qualified health center by the U.S. Department of Health and Human Services under the United States Public Health Service Act.

Freestanding Imaging Center. An institution that is licensed (where available) as a freestanding imaging center, freestanding diagnostic center, or freestanding radiology center.

Hearing Aid. A non-experimental, wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing, excluding batteries and cords and other assistive listening devices, including but not limited to frequency modulation systems.

Home Health Agency. An institution that is licensed as a home health agency.

Hospice. An organization that is licensed to provide Hospice Care.

Hospice Care. A holistic model of care for the terminally ill which is focused on comfort, rather than curative treatments. The Hospice care team is aimed at developing and implementing a plan of care with the Member and their family system, prioritizing pain management and symptom control. The majority of terminally ill persons receive hospice care in their home. Hospice care teams are on call 24/7 to address the needs of the Member. The hospice care team and services may include a physician, nurse, care manager, home health aide, social worker, spiritual care, physical therapy, occupational therapy, speech therapy, volunteers, durable medical equipment, medical supplies, medications, and bereavement.

Hospital. An institution that is duly licensed by a state as an acute care, rehabilitation, or psychiatric hospital and is certified to participate in the Medicare program under Title XVIII of the Social Security Act.

Inborn Errors of Metabolism. A genetically determined biochemical disorder in which a specific enzyme defect produces a metabolic block that may have pathogenic consequences at birth or later in life.

Infertility. Infertility means either of the following:

1. Being unable to conceive despite engaging in frequent sexual relations without contraception for a year or more; or

2. Having a condition that is a cause of infertility recognized by the American Congress of Obstetricians and Gynecologists , the American Urological Association, or another appropriate independent medical society.

In-Home Biometric Monitoring. The delivery of in-home monitoring devices that allows Providers to remotely monitor patients in their homes and enables secure, two-way flow of information between remote Providers and patients.

Inpatient. A Member admitted to a Hospital, Skilled Nursing Facility, or residential treatment facility for an overnight stay in a bed. "Inpatient" excludes a patient who is kept overnight in a Hospital solely for observation, regardless of whether the patient occupies a bed.

Inpatient Stay. A period of uninterrupted Inpatient confinement that begins with formal admission and ends upon discharge. An Inpatient Stay may include a Medically Necessary transfer from one Hospital to another Hospital as an Inpatient.

Maintenance Medications. A prescription drug that is prescribed to you by your Provider for treatment of a long-term condition or illness (e.g., blood pressure medication, cholesterol medication). Medications that are prescribed to treat short-term conditions (e.g., antibiotics) are not considered Maintenance Medications.

Maintenance Therapy. Any service, procedure, treatment, or therapy that has the primary purpose of preserving the present level of function and prevents deterioration of that function, as opposed to improving a function (within a reasonable timeframe established in a plan of care) to an extent that may allow for a more independent existence. Maintenance Therapy occurs when the condition of the patient receiving the service, procedure, treatment, or therapy does not or is not expected to materially improve within a reasonable timeframe established in a plan of care, or when the goals of a treatment plan have been met.

Maximum Allowable Charge or Maximum Allowance. The maximum amount that a Member and CHO will pay a Plan Provider for a Covered Service. The Maximum Allowable Charge or Maximum Allowance equals the Usual, Customary, and Reasonable Charge for a Covered Service.

Medicaid. A state medical assistance program under Title XIX of the United States Social Security Act, Grants to States for Medical Assistance Programs, known as "MaineCare" in the State of Maine.

Medical Emergency (Emergency Medical Condition). A medical condition, physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the health, physical or mental, of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

2. Serious impairment to bodily functions;

3. Serious dysfunction of any bodily organ or part; or

4. For pregnant women, having contractions and there is inadequate time for a transfer to another Hospital before delivery or that transfer may pose a threat to the health or safety of the woman or unborn child.

Medical Necessity or Medically Necessary. Health care services or products provided to a Member for the purpose of preventing, diagnosing, or treating an illness, injury, or disease or the symptoms of an illness, injury, or disease in a manner that is:

1. Consistent with generally accepted standards of medical practice;
2. Clinically appropriate in terms of type, frequency, extent, site, and duration;
3. Demonstrated through scientific evidence to be effective in improving health outcomes;
4. Representative of best practices in the medical profession; and
5. Not primarily for the convenience of the Member or Provider.

Medicare. The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

Member. Any person, including Dependents, covered by this Agreement.

Non-Plan Providers. Health care Providers that do not have a written agreement with CHO to provide health care services under this Agreement. Providers who have not contracted or affiliated with our specified subcontractor(s) for the services they perform under this plan are also considered Non-Plan Providers.

Open Enrollment. The timeframes described in section 3.A where individuals may first enroll for coverage under the Plan. These are also the timeframes when current Members may change plans offered by CHO.

Orthognathic Surgery. A branch of oral surgery dealing with the cause and surgical treatment of malposition of the bones of the jaw and occasionally other facial bones.

Orthotic Device. A device that restricts, eliminates, or redirects motion of a weak or diseased body part.

Out-of-Pocket Cost. The portion of the cost of services for which the Member is personally responsible. Out-of-Pocket Costs include Copayments, Coinsurance, and Deductibles.

Outpatient. A patient, not an Inpatient or Day Treatment Program participant, who obtains services at a facility of a Provider. Outpatient includes an overnight observation in a Hospital, even if the patient uses a bed.

Physician. A licensed medical doctor (MD) or doctor of osteopathic medicine (DO).

Placed for Adoption or Placement for Adoption. The assumption and retention of a legal obligation for the total or partial support of a child in anticipation of adoption of the child. If the legal obligation ceases to exist, the child is no longer considered Placed for Adoption.

Plan Provider. Licensed or certified Providers who are under contract with CHO to provide care to the Plan Members. Plan Providers are listed in the Provider Directory.

Premium. The periodic fee required for coverage of Members as provided in this Agreement.

Primary Care Provider ("PCP"). A Physician specialist in internal medicine, family practice, general practice, pediatrics, or obstetrics and gynecology, or a certified nurse practitioner or certified nurse midwife licensed by the applicable state nursing board, who is under contract with CHO to provide and authorize Members' care.

Prior Approval. The system by which a Member must first have approval from CHO before receiving Covered Services.

Provider. A licensed health care institution, facility, or agency or an independently billing, licensed, or certified health care professional acting within the scope of his or her license or certification. Providers also include (i) health care institutions, facilities, agencies, and professionals that have written participating agreements with us (Plan Providers), and (ii) other health care institutions, facilities, agencies, and professionals as required by law.

Provider Directory. A list of Plan Providers, including PCPs and Specialists. The Provider Directory may be updated without prior notice.

Radiation Therapy. The use of high energy penetrating rays to treat an illness or disease.

Referral. The recommendation of a Provider (usually the PCP) for a Member to receive Covered Services from another Provider.

Rider. A written attachment to this Agreement purchased by or on behalf of a Member that provides for additional, different, or reduced Covered Services, or another document that otherwise modifies the terms of this Agreement. In the event of a conflict between the terms and conditions of this Agreement and the terms and conditions of a Rider, the terms and conditions of a Rider shall rule.

Rural Health Clinic. An institution that is certified by the U.S. Department of Health and Human Services under the United States Rural Health Clinic Services Act.

Skilled Nursing Facility (SNF). An institution that meets all of the following requirements:

1. Licensed as a Skilled Nursing Facility;
2. Approved for payment of Medicare benefits, or otherwise qualified to receive approval for payment of Medicare benefits;
3. Primarily engaged in providing, in addition to room and board, skilled nursing care under the supervision of a duly licensed Physician;
4. Provides continuous 24-hours-a-day nursing service by or under the supervision of a registered nurse; and
5. Maintains a daily record for each patient.

Special Enrollment. Enrollment of a Member or Dependent under the Plan as allowed under section 3.A.2. Special Enrollment is allowed after certain events happen.

Specialist. A Provider who practices in a specialty area of medicine, including, but not limited to, radiology, cardiology, surgery, orthopedics, and oncology.

Stabilized. With respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result or occur before an individual can be transferred.

Subscriber. The person who meets the eligibility requirements to be a Member as described in this Agreement and who is not a Dependent. For a person to qualify as a Subscriber, we must have received and approved the required *Application* and Premium.

Substance Abuse Treatment Facility. A residential or nonresidential institution that meets all of the following requirements:

1. Licensed or certified as a Substance Abuse Treatment Facility;
2. Provides care to one or more patients for alcoholism and/or drug dependency; and
3. Is a freestanding unit or a designated unit of another licensed health care facility.

Urgent Care. Medical care or treatment with respect to which the application of the time periods for making non-urgent Prior Approval decisions could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, or, in the opinion of an attending Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. This does not include Medical Emergency services. Urgent Care does not include medical care or treatment with respect to a Medical Emergency.

Usual, Customary, and Reasonable Charge. As determined by CHO, an amount that is consistent with a usual range of charges by Providers for the same, or similar, services, equipment, or

supplies in the geographic area where the service, equipment, or supply was provided to a Member.

Utilization Review. The process CHO uses to determine the Medical Necessity, appropriateness, effectiveness, or efficiency of health care services. Techniques include Inpatient admission review, continued Inpatient Stay review, discharge planning, post-admission review, and case management.

Appendix A
Description of Dental Benefits Program

Dental benefits are only available to persons who are 18 years of age or less as of the effective date of coverage, except as provided in the Member Benefit Agreement.

Dental benefits are administered by Delta Dental Plan of Maine on behalf of Community Health Options.

Northeast Delta Dental

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1. Introduction

The dental benefits program of Community Health Options ("CHO") is administered by Delta Dental Plan of Maine d/b/a Northeast Delta Dental. We'd like you to know something about Delta Dental...

Delta Dental is a not-for-profit organization originally established and supported by Dentists to make Dental Care more available to the general public.

Delta Dental is affiliated with a national association known as the Delta Dental Plans Association ("DDPA") which provides Dental Care programs in all states and U.S. territories.

A substantial majority of Dentists in Maine participate with Delta Dental through Participating Agreements. In addition, there is a nationwide network of Delta Dental Participating Dentists available to you.

You are encouraged to take advantage of your dental benefits because good oral health is an important part of your overall general health. You are also encouraged to obtain your Dental Care from a Delta Dental PPO Dentist to receive the best value from your plan.

The dental benefits offered by Delta Dental pursuant to this policy are governed by certain policies and procedures of the US Department of Health and Human Services ("HHS") and the Maine Bureau of Insurance (the "Maine Bureau") for certified plans offered through the federally-facilitated Health Insurance Marketplace (the "FFM"). To the extent applicable, Delta Dental intends to comply with the policies and procedures of the applicable state and federal regulators in the offering and administration of the dental benefits governed by this plan.

2. Defined Words

At the end of this Appendix you will find a Glossary of defined words used in this Appendix. You will also find elsewhere in this Appendix other defined words. These defined words begin with capital letters. It is important that you understand what these defined words mean. If a word is not defined in this Appendix, please consult the Glossary in the Agreement.

When this Appendix uses the words "we," "us," and "our," this means Delta Dental and its designated affiliates. When this Appendix uses the words "you" and "your," this means the Subscriber and all Members and Dependents.

Unless otherwise clearly noted, lengths of time expressed in terms of days in this Appendix shall mean calendar days.

3. What Your Plan Pays

The coverage selected for your dental benefits program uses Delta Dental's PPO network of Participating Dentists. This Delta Dental PPO network program allows you to go to any Dentist of your choice and receive a level of benefits for covered services, but you will generally receive the best value from your plan if you visit a Delta Dental PPO Dentist. For the purpose of determining applicable Out-of-Pocket Cost, only Delta Dental PPO Dentists shall be deemed to be "Plan Providers" under the Agreement. Only your payments to Delta Dental PPO Dentists shall accrue to the Out-of-Pocket Costs for Plan Providers as specified in your *Schedule of Benefits*.

Your plan's payment is based on the "allowed charge" for a covered service received. The allowed charge is determined by whether the provider of the services is a Delta Dental PPO Dentist, participates with Delta Dental as a Premier Dentist, or does not participate with Delta Dental.

1. If the Dentist is a Delta Dental PPO Dentist, the allowed charge will be the lesser of the actual submitted charge or Delta Dental's allowance for PPO Dentists in the geographic area in which the services were provided. Your responsibility will be any applicable Deductible, Copayment, Coinsurance and payment for services not covered under your plan. The Dentist cannot receive in total more than Delta Dental's allowance for PPO Dentists and has agreed not to bill you for more than that amount.

2. If the Dentist is not a Delta Dental PPO Dentist, but is a Delta Dental Premier Dentist, the allowed charge will be the lesser of the actual submitted charge or Delta Dental's allowance for PPO Dentists in the geographic area in which the services were provided. Your responsibility will be any applicable Deductible, Copayment, Coinsurance, payment for services not covered under your plan, and any difference between your plan's payment and Delta Dental's allowance for Premier Dentists in the geographic area in which the services were provided. The Premier Dentist cannot receive in total more than such allowance for Premier Dentists and has agreed not to bill you for more than that amount.

3. If the Dentist is a Non-Participating Dentist or Other Dental Provider, the allowed charge will be the lesser of the actual submitted charge or Delta Dental's allowance for Non-Participating Dentists or ODPs in the geographic area in which the services were provided. Your responsibility will be any applicable Deductible, Copayment, Coinsurance, payment for services not covered under your plan, and any difference between your plan's payment and the provider's charge for the service. It is in your best interest to discuss what the charge will be before receiving the service.

Remember: All Delta Dental PPO Dentists and Delta Dental Premier Participating Dentists agree to:

• File your claim forms for you

• Charge you no more than the amount allowed for payment by Delta Dental

• Accept payment directly from Delta Dental

4. How to File a Claim

To Use Your Plan, Follow These Steps:

Please read this Appendix carefully to familiarize yourself with the benefits and provisions of your dental benefits program.

Ask your Dentist if he/she is a Delta Dental PPO Dentist or participates as a Delta Dental Premier Dentist; visit Delta Dental's website at **www.nedelta.com**, refer to the Delta Dental Participating Dentist Directory for a PPO Dentist, or call Delta Dental for information.

When you visit your dental office, inform them that you are covered under a Delta Dental program and provide your identification card or other means of verifying coverage. Your Dentist will perform an evaluation and plan the course of treatment. When the treatment has been completed, the claim form will be sent to Delta Dental for payment for covered services. Clean written claims must be paid in 30 days; clean electronic claims must be paid within 15 days.

Participating Dentists: Participating Dentists will have claim forms available in their offices. A Participating Dentist will not charge at the time of treatment for covered services, but may request payment for non-covered services, and applicable Deductibles, Copayments and Coinsurance. Delta Dental will pay the Participating Dentists directly based on the allowed charges. An

Explanation of Benefits will be sent or accessible to you which will indicate the amount you should pay, if any, to your Dentist.

Non-Participating Dentists or Other Dental Providers: Delta Dental provides benefits regardless of your choice of Dentist, participating or not. When visiting a Non-Participating Dentist or ODP (who is a person, other than a Dentist, who provides Dental Care and is authorized and licensed to provide such services by the state in which the services are rendered), you may be required to submit your own claim (available at www.nedelta.com) and pay for services at the time they are provided. All claims should be submitted to Delta Dental. Payment will be made directly to you. Some states may require that assignment of benefits (directing that payment be sent to the provider) be honored. In these instances, payment will be made directly to the Non-Participating Dentist or ODP when written notice of such an assignment is made on the claim. In either case, payment for treatment performed by a Non-Participating Dentist or ODP will be limited to the lesser of the actual submitted charge or Delta Dental's allowance for Non-Participating Dentists or ODPs in the geographic area in which services were provided. It is your responsibility to make full payment to the Dentist or ODP. When there is not sufficient fee information available for a specific dental procedure, Delta Dental will determine an appropriate payment amount.

You or someone in the dental office must fill in the patient information portion of the claim form. Please be sure information is complete and accurate to ensure the prompt and correct payment of your claim.

Prior Authorizations: For several identified procedures, Prior Authorization is required for Pediatric Members.

Please note that Prior Authorization does NOT guarantee payment. A new coverage period, additional paid benefits and/or a contract change may alter the final payment, because payment is based on information on file at the time treatment is provided (the date of service) which may be different than information available at the time the Prior Authorization was given. Any changes in a Dentist's participating status or Delta Dental's allowance may also affect your plan's final payment.

Predetermination of Benefits: Delta Dental strongly encourages Predetermination of cases involving costly or extensive treatment plans. Although it is not required, Predetermination helps avoid any potential confusion regarding your plan's payment and your financial obligation to the Dentist. A Predetermination voucher reflects your benefits based on the procedures and costs submitted by your dental office.

Please note that Predetermination does NOT guarantee payment. Rather, Predetermination is an estimate of payment based on your current benefits. A new coverage period, additional paid benefits and/or a contract change may alter the final payment, because payment is based on information on file at the time treatment is provided (the date of service) which may be different than information available at the time the Predetermination estimate was given. Any changes in a Dentist's participating status or Delta Dental's allowance may also affect your plan's final payment.

Questions concerning Prior Authorization and Predetermination should be directed to Delta Dental's Customer Service Department at 1-800-832-5700 or 603-223-1234.

5. Benefits

In this section of the Appendix, we give you the details of what services your dental benefits program covers and the conditions and limitations on those services. **This section includes significant dental terminology adopted by the American Dental Association. We encourage you to discuss proposed services and treatment plans with your Dentist/dental office.** In addition, should you have any questions regarding those services, you may call Customer Service at 1-800-832-5700 Monday through Friday from 8:00 a.m. to 4:45 p.m. EST excluding holidays.

Coverage A - Diagnostic & Preventive Benefits

Diagnostic: Oral evaluations – one time in a period of six (6) months. Evaluations can be comprehensive or periodic and may be provided by a specialist or a general Dentist.

Limited oral evaluations.

Radiographic images – complete series or panoramic image once in a period of five (5) years; bitewing images once in a period of twelve (12) months; images of individual teeth as necessary.

Caries risk assessment – one time in a period of three (3) years for Pediatric Members between the ages three (3) and nineteen (19).

Preventive: Prophylaxis (cleaning) – one time in a period of six (6) months (child prophylaxis through age thirteen (13), adult prophylaxis thereafter). This can be a routine prophylaxis under Diagnostic and Preventive Benefits or a periodontal maintenance under Basic Restorative Benefits.

A full mouth debridement is a covered benefit, once in a lifetime, under Major Restorative Benefits and, when performed, is counted towards your prophylaxis benefit.

Fluoride treatments – two (2) times in a period of twelve (12) months.

Sealants are a covered benefit.

Space maintainers are a covered benefit.

Palliative Treatment: Minor emergency treatment for the relief of pain.

NOTE: ***Time limitations are measured from the date the service was last performed.***

All covered services containing an age or frequency limitation are available for age exception or more frequent treatment only with Prior Authorization.

Diagnostic & Preventive Benefits - Exclusions and Limitations:

1. A limited oral evaluation is a covered benefit, and when performed, is counted towards your oral evaluation benefits.
2. Payment for an oral evaluation of any kind, within ninety (90) days after periodontal surgery, by the same Dentist/dental office is Disallowed.
3. Pre-diagnostic services, such as screening and assessment of a patient, are not covered benefits. Payment for a screening or assessment is Disallowed if billed with an oral evaluation.

4. A panoramic radiographic image, with or without supplemental radiographic images (such as periapicals, bitewings and/or occlusal), is considered a complete series for time limitations and any fee in excess of the fee for a complete series is Disallowed.

5. Payment for additional periapical radiographs within a thirty (30) day period of a complete series or panoramic image, unless there is evidence of trauma, is Disallowed.

6. When benefits are requested for a panoramic radiographic image in conjunction with a complete series by the same Dentist/dental office, fees for the panoramic radiographic image are Disallowed as a component of the complete series on the same date of service.

7. Routine working and final treatment radiographic images taken for endodontic therapy by the same Dentist/dental office are considered a component of the complete treatment procedure and separate fees are Disallowed on the same date of service.

8. If the fee for bitewing and occlusal radiographic images is equal to or exceeds the fee for a full mouth series, it is considered a full mouth series for payment purposes and time limitations. Any fee in excess of the fee for the full mouth series is Disallowed on the same date of service.

9. Cone beam imaging is not a covered benefit. Payment is Disallowed if billed with image interpretation.

10. Cephalometric images, oral/facial photographic images and diagnostic models are a covered benefit with Medically Necessary Orthodontic treatment only.

11 A prophylaxis done on the same date by the same Dentist/dental office as a periodontal maintenance, or scaling and root planing is considered to be part of and included in those procedures and the fee is Disallowed.

12. Cleanings (prophylaxis – a Diagnostic & Preventive benefit) are effectively included in both full mouth debridement (a Diagnostic & Preventive benefit) and periodontal maintenance (a Basic Restorative benefit). As a result, each of these procedures is counted toward your prophylaxis benefit of once in a six (6) month period.

13. Laboratory tests for caries susceptibility are not a covered benefit and are Disallowed when billed with an oral evaluation for Pediatric Members under the age of three (3).

14. Caries risk assessment is a covered benefit once in a period of three (3) years for Pediatric Members between the ages of three (3) and nineteen (19). Benefits for caries risk assessment is Disallowed if billed for children under the age of three (3), if billed within twelve (12) months by the same Dentist/dental office, or if performed with other risk assessments by the same Dentist/dental office.

15. The replacement of space maintainers is not a covered benefit. The patient is financially responsible.

16. The repair of space maintainers is not a covered benefit. The patient is financially responsible.

17. Recementation of a space maintainer is a covered benefit once in a lifetime per appliance.

18. Removal of a space maintainer is included as part of the total treatment. Charges for removal of a space maintainer are Disallowed if performed by the same Dentist/dental office as the initial placement or if performed with the recementation of a space maintainer.

19. Sealant benefits limitation:

(a) The sealant benefit is for the application of sealants to caries-free and restoration-free, occlusal (biting) surface of permanent molars only.

(b) The sealant benefit is provided no more than once in a three (3) year period per tooth.

(c) Sealants are Disallowed within two (2) years of initial placement on the same tooth by the same Dentist/dental office. A sealant is Disallowed if performed on the same tooth, by the same Dentist/dental office on the same date of service as a restoration which includes the occlusal surface.

20. Preventive resin restorations are a covered benefit once per tooth in a period of three (3) years on permanent molars for Pediatric Members only. Fees are Disallowed if replaced by the same Dentist/dental office within twenty-four (24) months. A preventive resin restoration is Disallowed if performed on the same tooth, by the same Dentist/dental office on the same date of service as another restoration.

21. The fee for preventive resin restoration is Disallowed if performed on the same date of service as a conventional restoration or palliative treatment by the same Dentist/dental office.

22. Pulp vitality tests are a covered benefit only when done in conjunction with a radiographic image, a limited oral evaluation, a palliative treatment or a protective restoration. Payment is otherwise Disallowed.

23. Palliative treatment is a covered benefit. The third palliative treatment claim received in 180 days is subject to dental consultant's review.

24. Palliative treatment is part of the initiation of endodontic therapy and therefore is included in the fee when performed on the same date by the same Dentist/dental office and a separate fee is Disallowed.

25. The fee for palliative treatment is Disallowed when submitted with all procedures except radiographic images and diagnostic codes and is performed by the same Dentist/dental office on the same date.

26. Viral culture tests, saliva tests, and oral cancer screening are not covered benefits. The patient is financially responsible.

27. Nutritional counseling, tobacco counseling and oral hygiene instruction are not covered benefits. The patient is financially responsible.

28. TMJ related services are not covered benefits. The patient is financially responsible.

Coverage B - Basic Restorative Benefits

Restorative: Amalgam (silver) restorations (fillings).
Resin (white) restorations (fillings) on anterior (front) teeth.
Prefabricated Stainless Steel Crowns.
Recementation of an inlay or crown.
Protective restorations.

Periodontal Maintenance: Prophylaxis (cleaning) – one time in a period of six (6) months (child prophylaxis through age thirteen (13), adult prophylaxis thereafter). This can be a routine prophylaxis under Diagnostic and Preventive Benefits or a periodontal maintenance under Basic Restorative Benefits.

	A full mouth debridement is a covered benefit, once in a lifetime, under Major Restorative Benefits and, when performed, is counted towards your prophylaxis benefit.
Periodontics:	Periodontal scaling and root planing is a covered benefit once in a period of twenty-four (24) months.
Endodontics:	Pulpotomy and pulpal therapy.
Oral Surgery:	Extractions and covered surgical procedures.
Prosthodontic Services:	Denture repair, adjustment, rebase and reline.
Tissue conditioning:	Two (2) times in a three (3) year period.

Anesthesia: General anesthesia, intravenous sedation, or non-intravenous conscious sedation are covered benefits when done in conjunction with other covered services.

Note: ***Time limitations are measured from the date the service was last performed.***

All covered services containing an age or frequency limitation are available for age exception or more frequent treatment only with Prior Authorization.

Basic Restorative Benefits - Exclusions and Limitations:

1. Resin or amalgam restorations are covered once per tooth every twenty-four (24) months, irrespective of the number or combination of procedures performed. The replacement of amalgam (silver) or resin (white) restorations within twenty-four (24) months by the same Dentist/dental office is Disallowed.
2. Resin restorations on posterior teeth (white fillings in bicuspids and molars) are optional. An allowance will be paid equal to an amalgam (silver) restoration. If a resin restoration is performed, the patient is responsible for any additional fee.
3. Resin based composite crowns on anterior teeth are a covered benefit once in a period of two (2) years per tooth for Pediatric Members age twelve (12) and older. Payment is Disallowed if replaced within two (2) years by the same Dentist/dental office.
4. An adjustment will be made for two (2) or more restoration surfaces which are normally joined together. A Delta Dental Participating Dentist agrees not to charge a separate fee.
5. Prefabricated stainless steel crowns are a covered benefit once in a period of twenty-four (24) months. The fee for replacement of a stainless steel crown by the same Dentist/dental office within twenty-four (24) months is included in the initial crown placement and is Disallowed.
6. Recementation of a metallic inlay, onlay, or crown or partial coverage restoration is a covered benefit once in a lifetime. Payment for recementation of an inlay, onlay, crown or partial coverage restoration is Disallowed when performed within six (6) months of the initial placement by the same Dentist/dental office.
7. Protective restorations are Disallowed if performed on the same date of service as a palliative treatment by the same Dentist/dental office.
8. A prophylaxis done on the same date by the same Dentist/dental office as a periodontal maintenance, or scaling and root planing is considered to be part of and included in those procedures and the fee is Disallowed.

9. Fees for periodontal maintenance, when billed within three (3) months of periodontal therapy by the same Dentist/dental office, are Disallowed.

10. Periodontal scaling and root planing is a covered benefit per quadrant once in a period of twenty-four (24) months. Benefits are paid for a maximum of two (2) quadrants per office visit. Fees are Disallowed for twenty-four (24) months after the initial therapy if the retreatment is performed by the same Dentist/dental office. If treatment is done by a different Dentist within twenty-four (24) months, benefits are Denied. The patient is responsible for the fee.

11. A partial pulpotomy is a covered benefit, once per tooth per lifetime, on permanent teeth only. The fee for a partial pulpotomy is Disallowed if performed within thirty (30) days on the same tooth by the same Dentist/dental office as root canal therapy.

12. Pulpal therapy or therapeutic pulpotomy is a covered benefit once in a three (3) year period per tooth on primary teeth only.

13. Pulpal debridement is a covered benefit once in a three (3) year period. The fee for pulpal debridement is Disallowed if performed within thirty (30) days of a root canal treatment by the same Dentist/dental office.

14. Routine post-operative visits are considered part of, and included in the fee for, the total procedure. A Delta Dental Participating Dentist agrees not to charge a separate fee.

15. Pin retention is a covered benefit once per tooth in a period of twenty-four (24) months in conjunction with all restorations. Additional pins in the same tooth are Disallowed. Pin retention is Disallowed when billed in conjunction with a core build-up.

16. Post-operative treatment of complications from oral surgery is a covered benefit once per surgical site, subject to a dental consultant's review. The fee for post-operative treatment of complications is Disallowed if performed within thirty (30) days by the same Dentist/dental office as the oral surgery.

17. Surgical removal of residual tooth roots is Disallowed when performed on the same date of service as an extraction by the same Dentist/dental office.

18. Alveoplasty is included in the fee for surgical extractions. Separate fees for these procedures are Disallowed if performed by the same Dentist/dental office in the same surgical area on the same date.

19. A frenulectomy or frenuloplasty is a covered benefit once per site per lifetime and is Disallowed when billed on the same date as any other surgical procedure in the same surgical area by the same Dentist/dental office.

20. A consultation performed by a practitioner who is not performing further services is a covered benefit. A consultation is Disallowed if performed in conjunction with an oral evaluation by the same Dentist/dental office on the same date of service.

21. Exploratory surgical services are not a covered benefit. The patient is financially responsible.

22. Fee for repair of a complete denture is a covered benefit two (2) times per denture in a twelve (12) month period. Fees for a denture repair cannot exceed half the fees for a new appliance, and any excess fee billed by the same Dentist/dental office is Disallowed on the same date of service.

23. Fees for adjustments or repairs of complete or partial dentures, if performed within six (6) months of initial placement by the same Dentist/dental office are Disallowed

24. The relining of a denture is a covered benefit two (2) times in a period of twelve (12) (months. The fee for reline of a denture cannot exceed one-half of the fees for a new appliance, and any excess fee by the Dentist/dental office is Disallowed on the same date of service.

25. The rebase of a denture is a covered benefit once in three (3) years. The fee for rebase of a denture cannot exceed one-half of the fee for a new appliance, and any excess fee by the same Dentist/dental office is Disallowed on the same date of service.

26. The reline or rebase of a denture is Disallowed if performed within six (6) months of initial placement by the same Dentist/dental office.

27. Rebase and reline include adjustments required within six (6) months of delivery. When an adjustment is billed within six (6) months of a rebase or reline by the same Dentist/dental office, fees for the adjustment are Disallowed.

28. Recementation of a fixed partial denture is a covered benefit once in a period of twelve (12) months. Fees for recementation of fixed partial dentures are Disallowed if done within six (6) months of the initial placement by the same Dentist/dental office.

29. Recementation of a cast or prefabricated post and core is a covered benefit once per tooth per lifetime. Payment is Disallowed if performed within six (6) months of the initial placement by the same Dentist/dental office, or if performed on the same date of service of a crown recementation by the same Dentist/dental office.

30. Tissue conditioning is a covered benefit two (2) times in a three (3) year period. The fee for tissue conditioning is not a benefit if performed on the same day the denture is delivered or a reline/rebase is provided by the same Dentist/dental office and is Disallowed.

31. Tooth preparation, bases, copings, protective restorations, impressions, and local anesthesia, or other services that are part of the complete dental procedure, are considered components of, and included in the fee for, a complete procedure.

32. Therapeutic drug injections are a covered benefit subject to dental consultant review.

33. Local anesthesia in conjunction with any procedure by the same Dentist/dental office is considered part of the overall procedure and fees are Disallowed.

34. Excision of lesions is not a covered benefit. The patient is financially responsible.

Please note: ***Certain procedures for Pediatric Members as expressly identified require Prior Authorization from Delta Dental. Separate from any required Prior Authorization, Delta Dental strongly encourages Predetermination of cases involving costly or extensive treatment plans. Although it's not required, Predetermination helps avoid any potential confusion regarding Delta Dental's payment and your financial obligation to the Dentist.***

Coverage C - Major Restorative Benefits

Restorative Crowns and Onlays: Crowns and metallic inlays and onlays when a tooth cannot be adequately restored with amalgam (silver) or resin (white) restorations. Core build-ups, prefabricated post and cores, and crown repair for Pediatric Members age twelve (12) and older.

Endodontics:	Root canal therapy, apicoectomy, apexification, root amputation, and hemisection.
Periodontics:	Full mouth debridement, gingivectomy, gingivoplasty, gingival flap procedure, clinical crown lengthening, osseous surgery, and soft tissue graft.
Prosthodontics:	Fixed partial dentures (abutment crowns and pontics); removable complete and partial dentures, and pin retention.
Implant Services:	Surgical placement of an endosteal implant body including healing cap for Pediatric Members age sixteen (16) and older.
Implant Supported Prostheses:	Crowns, fixed or removable partial dentures, and full dentures anchored in place by an implanted device for Pediatric Members age sixteen (16) and older.
Occlusal Guard:	Once in a five (5) year period for Pediatric Members age thirteen (13) and older.

Note: ***Time limitations are measured from the date the service was last performed.***

All covered services containing an age or frequency limitation are available for age exception or more frequent treatment only with Prior Authorization.

Major Restorative Benefits - Exclusions and Limitations:

1. Inlays and onlays (metallic) and crowns made of resin-based composite, porcelain, porcelain fused to metal, full cast metal, or resin fused to metal, where the metal is high noble metal, titanium, noble metal or predominantly base metal, are not benefits for Pediatric Members under the age of twelve (12) without a Prior Authorization.
2. Time limitations:
   (a) One (1) complete maxillary (upper) and one (1) complete mandibular (lower) denture in a period of seven (7) years.
   (b) One (1) immediate maxillary (upper) and one (1) immediate mandibular (lower) denture in a lifetime.
   (c) A removable or fixed partial denture in a period of seven (7) years unless the loss of additional teeth requires the construction of a new appliance.
   (d) Metallic onlays, crowns, core buildups, and post and cores are a benefit once per tooth in a period of seven (7) years.
3. The fees for core buildups or post and core are Disallowed when performed in conjunction with inlays, ¾ crowns or onlays.
4. A provisional crown is considered part of a crown procedure when performed by the same Dentist/dental office as a permanent crown, and a separate fee is Disallowed.
5. An indirectly fabricated post and core in addition to a crown is payable only on an endodontically treated tooth. Fees for post and cores are Disallowed when radiographic images indicate an absence of endodontic treatment, incompletely filled canal space or unresolved pathology associated with the involved tooth. Each additional post in the

same tooth is considered part of the post and core procedure and a separate fee is Disallowed.

6. Root canal therapy is a covered benefit once per tooth in a period of twenty-four (24) months. Retreatment of root canal therapy or retreatment of apical surgery by the same Dentist/dental office within twenty-four (24) months is considered part of the original procedure. Fees for the retreatment by the same Dentist/dental office are Disallowed.

7. Post removal is Disallowed if performed within thirty (30) days of an endodontic treatment and by the same Dentist/dental office performing the endodontic treatment.

8. Direct or indirect pulp caps are a covered benefit once per tooth in a period of three (3) years. A pulp cap performed on the same date of service as the final restoration by the same Dentist/dental office is considered part of a single complete restorative procedure and the fee for the pulp cap is Disallowed.

9. Root amputation performed in conjunction with an apicoectomy by the same Dentist/dental office is Disallowed.

10. Periodontal surgical procedures include all necessary postoperative care, finishing procedures, evaluations for three (3) months, as well as any surgical re-entry, except soft tissue grafts, for three (3) years. When a surgical procedure is billed within three (3) months of the initial surgical procedure by the same Dentist/dental office, the fee for the surgery is Disallowed.

11. Gingivectomy, gingivoplasty, gingival flap procedure, osseous surgery, or soft tissue graft procedure is a benefit once in a period of three (3) years. Periodontal surgery performed within three (3) months of the initial surgery by the same Dentist/dental office is Disallowed. The charge for surgical re-entry by the same Dentist/dental office within three (3) years is Disallowed. . A gingivectomy for the removal of hyperplastic tissue (D7970) is not a covered benefit unless diseased tissue is present.

12. An apexification or an apicoectomy is a covered benefit once per tooth in a period of three (3) years. Retreatment by the same Dentist/dental office within twenty-four (24) months is Disallowed.

13. An internal root repair is not a covered benefit, and if performed on a primary tooth, the benefit is denied. The fee for an internal root repair is Disallowed if performed on a permanent tooth or if performed on the same date of service by the same Dentist/dental office as an apicoectomy or retrograde filling.

14. Retrograde fillings are a covered benefit once per tooth per three (3) years. Retreatment within twenty-four (24) months of the original procedure by the same Dentist/dental office is Disallowed.

15. Periradicular surgery without an apicoectomy performed on the same tooth, on the same date, by the same Dentist/dental office as an apicoectomy, retrograde filling and/or root amputation is Disallowed.

16. Reattachment of a tooth fragment, including the incisal edge or cusp, is a covered benefit. Payment is Disallowed if performed within twenty-four (24) months of a restoration on the same tooth by the same Dentist/dental office.

17. Clinical crown lengthening is a covered benefit once per tooth in a three (3) year period and only when performed in a healthy periodontal environment in which bone must be removed for placement of the restoration or crown. The fee for clinical crown

lengthening is Disallowed if performed on the same date of service by the same Dentist/dental office as the crown placement.

18. Clinical crown lengthening, when done in conjunction with osseous surgery, crown preparations, or restorations is considered a component of, and included in the fee for, the complete procedure and is Disallowed.

19. Clinical crown lengthening, when performed in conjunction with other periodontal procedures, will be subject to a dental consultant's review. Payment will be based on the most comprehensive procedure.

20. An interim partial or complete denture is not a covered benefit. Fees are Disallowed if billed in conjunction with a permanent appliance.

21. If abutment teeth have moved to partially close an edentulous area, only the number of pontics necessary to fill that area are a covered benefit. The patient will be responsible for any additional fee.

22. Sectioning of a fixed partial denture in order to remove the denture prior to placing a new denture is Disallowed. Sectioning of a fixed partial denture to preserve a portion of the denture for continued use may be covered but is subject to review by a dental consultant.

23. An implant body including healing cap is a benefit once in a seven (7) year period for Pediatric Members age sixteen (16) and older.

24. Implant services and implant supported prosthetics are not a covered benefit for Pediatric Members under the age of sixteen (16).

25. Eposteal and transosteal implants are optional. An allowance will be paid equal to an endosteal implant for Pediatric Members age sixteen (16) and older. The patient will be responsible for any additional fee.

26. Removal of an implant is a covered benefit once per tooth site.

Coverage D - Orthodontic Benefits

Medically Necessary Orthodontia:

Medically Necessary Orthodontic treatment and procedures (subject to Prior Authorization) required for the correction of malposed (crooked) teeth.

Placement of device to facilitate eruption of an impacted tooth.

Medically Necessary Orthodontic Benefits - Exclusions and Limitations:

1. For Medically Necessary Orthodontic treatment commenced while a Pediatric Member is eligible for orthodontic benefits under this policy, Delta Dental will initiate payment of its liability once bands or orthodontic devices are placed. Delta Dental requires dental consultant review to determine if orthodontic treatment is medically necessary.

2. For Medically Necessary Orthodontic treatment commenced prior to becoming eligible under this policy, Delta Dental will pro-rate its liability based on the number of remaining months of active treatment compared to the total number of months of active treatment. Delta Dental requires dental consultant review to determine if orthodontic treatment was medically necessary at the start of treatment.

3. Active treatment includes procedures undertaken and appliances used with those procedures for the purpose of bringing teeth into proper position and alignment. Active

treatment does not include space maintainers, palate expanders or other devices used to prepare the patient for services to position and align teeth.

4. Your plan will make one (1) payment of twenty-five percent (25%) of the allowed charge at the start of treatment followed by monthly payments throughout the length of treatment up to a maximum of thirty-six (36) months for its total liability. "Start of treatment" means the date of initial banding or a segment thereof, or a device is placed in the patient's mouth. Periodic monthly payment will continue based upon the continuing eligibility of the Pediatric Member.

5. Cephalometric images, oral/facial photographic images and diagnostic models are a covered benefit with Medically Necessary Orthodontic treatment only.

6. The replacement of an orthodontic appliance is a covered benefit once per arch in a lifetime.

7. The repair of an orthodontic appliance is not a covered benefit. The patient is financially responsible.

8. Recementation of a fixed retainer is a covered benefit once in a lifetime if performed by a different Dentist than the Dentist who placed the appliance. Fees are Disallowed if performed by the same Dentist/dental office as placement of the appliance.

Please note: ***Certain procedures for Pediatric Members as expressly identified require Prior Authorization from Delta Dental. Separate from any required Prior Authorization, Delta Dental strongly encourages Predetermination of cases involving costly or extensive treatment plans. Although it's not required, Predetermination helps avoid any potential confusion regarding Delta Dental's payment and your financial obligation to the Dentist.***

6. Waiting Periods and General Exclusions and Limitations

A. Waiting Periods Generally:

There is a twenty-four (24) month waiting period in connection with Medically Necessary Orthodontic benefits for Pediatric Members.

Exclusions:

B. The dental benefits provided by Delta Dental shall **not include** the following:

1. Services for injuries or conditions compensable under Worker's Compensation or Employer's Liability Laws.

2. Services that are determined by Delta Dental to be rendered for cosmetic reasons, such as bleaching or whitening of teeth (unless discolored by previous endodontic therapy), placement of veneers, correction of congenital malformations, or cosmetic surgery. This exclusion is not intended to exclude services provided to newborn children for congenital defects or birth abnormalities.

3. Services completed when Pediatric Members were not covered under the policy. Such services include, but are not limited to, endodontics and prosthodontics (including restorative crowns and onlays).

4. Services not provided by a Dentist, an independent practice dental hygienist, or under the supervision of a Dentist, or that are not within the scope of the license of the Dentist, the independent practice dental hygienist, or the person supervised by the Dentist, unless otherwise required by law.

5. Prescription drugs or the application of anti-microbial agents.

6. Charges for: (i) hospitalization; (ii) preventive control programs; (iii) myofunctional therapy; (iv) treatment of temporomandibular joint (TMJ) dysfunction and related diagnostic procedures; (v) equilibration; and (vi) gnathological reporting.

7. Charges for failure to keep a scheduled visit with the Dentist.

8. Charges for completion of forms. Such charges shall not be made to Pediatric Member by Participating Dentists.

9. Dental Care which is not necessary and customary, as determined by generally accepted dental practice standards.

10. Dental Care or supplies which are not within the benefits for the option selected.

11. Appliances, procedures, or restorations for: (i) increasing vertical dimension; (ii) analyzing, altering, or restoring occlusion; (iii) replacing tooth structure lost by attrition or abrasion; (iv) correcting congenital or developmental malformations; or (v) esthetic purposes. This exclusion is not intended to exclude services provided to newborn children for congenital defects or birth abnormalities.

12. Payments of benefits incurred by you and/or the Pediatric Member after the date on which the Pediatric Member becomes ineligible for benefits.

13. Charges for Dental Care or supplies for which no charge would have been made in the absence of dental benefits.

14. Charges for Dental Care or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared.

15. Temporary services or incomplete treatment.

16. A consultation unless performed by a practitioner who is not performing further services.

17. Case presentation and treatment planning. You or the Pediatric Member will be responsible for any additional fee.

Limitations:

C. The dental benefits provided by Delta Dental shall be limited as follows unless otherwise required by Maine law:

1. Dental Care rendered by anyone other than a Dentist shall not be a benefit, except that scaling or cleaning of teeth and topical application of fluoride and such other treatment performed by a licensed dental hygienist shall be a benefit, so long as either:

   (i) the treatment is rendered under the supervision and guidance of a Dentist, in accordance with generally accepted dental practice standards; or

(ii) the treatment is rendered by an independent practice dental hygienist within the lawful scope of practice of that independent practice dental hygienist.

2. Optional Dental Care: In all cases in which you or the Pediatric Member agree, after consultation with your Dentist, to more expensive Dental Care than is customarily provided, your plan will pay its applicable coinsurance percentage for the Dental Care which is customarily provided to restore the tooth to contour and function. You or the Pediatric Member shall be responsible for the remainder of the Dentist's fee.

3. Predetermination and Prior Authorization do not guarantee payment. Payment is based upon eligibility, benefits selected, allowable charges at the time the Dental Care is actually rendered and the Dentist's participating status with Delta Dental.

4. Services completed or in progress at the Pediatric Member's date of death will be paid in full to the limit of your plan's liability.

5. When services for Dental Care in progress are interrupted and completed thereafter by another Dentist, Delta Dental will review the claim to determine the payment, if any, due each Dentist.

6. Specialized techniques including, but not limited to, precision attachments, overdentures and procedures associated therewith, and personalizations or characterization are excluded. You or the Pediatric Member will be responsible for part of or the entire fee for these services.

7. Interpreter services are a covered benefit when performed in conjunction with other covered services.

8. Delta Dental programs provide amalgam (silver) and resin (white) restorations for treatment of caries. If the teeth can be restored with such materials, any gold restorations, or crowns are also considered optional. You or the Pediatric Member will be responsible for any additional fee.

9. Written notice of sickness or of injury must be given to your plan within twenty (20) days after the date when such sickness or injury occurred or as soon thereafter as reasonably possible. Failure to give notice within such time shall not invalidate nor reduce any claim, if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

10. Delta Dental, upon receipt of a notice of claim, will furnish to you such forms as are usually furnished by it for filing claims. If such forms are not furnished within fifteen (15) days after you give such notice, you shall be deemed to have complied with the requirements of this plan with the time fixed in the plan for filing claims. Notice given by or on behalf of you to Delta Dental, or to any authorized agent of Delta Dental, with information sufficient to identify you, shall be deemed notice to your plan.

11. A completed claim (or satisfactory written proof acceptable to Delta Dental) must be furnished to Delta Dental at its principal office within twelve (12) months from the date the Dentist provided Dental Care. No payment will be made on claims with dates of service in excess of the twelve (12) month limitation. Benefits payable under this plan for any claim will be paid promptly upon receipt of written notice of claim.

12. The Date of Incurred Liability refers to the date a service is subject to the applicable Deductible, Copayment, Coinsurance, and limitations. Except as otherwise noted, the total cost of the service is applied to the Plan Year during which the service is completed, irrespective of the Plan Year in which the service is started.

    For services covered, your plan's date of incurred liability for multiple visit procedures is as follows:

    (i) Restorative Crowns (Pediatric Members under the age of twelve (12) require a Prior Authorization) — Total cost for crowns shall be incurred on the date that the crown or onlay is cemented.

    (ii) Fixed Partial Dentures (abutment crowns and pontics) — The total cost for fixed partial dentures shall be incurred on the date that the appliance is cemented.

    (iii) Removable Complete and Partial Dentures — Total cost for removable complete and partial dentures shall be incurred on the date that the appliance is delivered to the Pediatric Enrollee.

    (iv) Endodontics — Total cost for endodontic treatment shall be incurred when the canal is filled to completion.

    (v) Implant Body (Pediatric Members age sixteen (16) and older) — Total cost for the implant body, including healing cap, shall be incurred on the date of the surgical placement.

    (vi) Implant Prosthetics (Pediatric Members age sixteen (16) and older) — Total cost for the prosthetic portion of an implant shall be incurred on the date that the appliance is cemented or delivered to the patient.]

7. Claims Review and Appeal

A. General Claims Inquiry:

After a claim is submitted by your Dentist and processed by Delta Dental, you and/or the Pediatric Member will be sent or have access to an Explanation of Benefits. This notice will explain the benefits that were paid on your behalf, let you know if any services are denied, and give you the reason(s) for the denial.

If you have any questions regarding your benefits, you may call Delta Dental for an explanation at 603-223-1234. The toll-free number is 1-800-832-5700. You will be connected directly to our Customer Service Department.

The Customer Service Representative will need to know the claim number that is located on your Explanation of Benefits or, if that information is not available, the Subscriber's identification number and date of treatment. This will enable a quick response to your inquiry.

B. Disputed Claims Procedure:

After you have followed the General Claims Inquiry procedure and have reason to believe your benefit determination was not in accordance with the terms of your plan, you have the option of using Delta Dental's Disputed Claims Procedure. This may be requested within six (6) months of the date of Delta Dental's original Explanation of Benefits. It is recommended that your written request for a review of your claim be personally delivered or mailed certified mail, return receipt requested, to the Vice President, Professional Relations, Delta Dental, One Delta Drive, PO Box

2002, Concord, New Hampshire, 03302-2002, but you may also submit your request by standard mail.

Your request for a review of your claim should refer to the claim(s) in question, state your name and address, and the reasons you think the denial should be evaluated, and provide any additional materials you wish to present.

The Vice President, Professional Relations, or his designee, may request additional documents as necessary to make such a review and will promptly review your claim. If the claim is wholly or partially denied, you will be furnished with a notice of the decision within thirty (30) days after receipt of the disputed claim. The written notice will include:

1. the specific reason(s) for denial, and

2. the specific reference to the provision of this Agreement upon which the denial is based.

If your request for review results in an additional payment, it will be made within fifteen (15) working days of the Vice President, Professional Relations' response.

If you do not receive notice within the thirty (30) day period, the claim is considered denied in order that you may proceed to the Disputed Claims Review Procedure.

If you have any problem securing a review of your claim, you may also contact:

Community Health Options
Mail Stop 100
Attn: Member Services
PO Box 1121
Lewiston, ME 04243
Telephone: 1-855-624-6463 (TTY/TDD: 711) Fax: 1-207-402-3745

Maine Bureau of Insurance
34 State House Station
Augusta, ME 04333
Telephone: 1-800-300-5000 (within Maine) or 1-207-624-8475 (outside Maine)

C. Disputed Claims Review Procedure

The Disputed Claims Review Procedure allows you to request a review from Delta Dental's Disputed Claims Review Committee after receipt of written notification of the Vice President, Professional Relations' denial of your claim. The Review Committee is composed of Participating Dentists, non-dentist members of the Board of Directors, and representatives of purchasers.

You or your duly authorized representative may appeal to the Review Committee by filing a request for review within one hundred eighty (180) days from receipt of Vice President, Professional Relations' notice denying the claim, or, if no date is given, within six (6) months of the notice. It is recommended that your written request should be sent certified mail, return receipt requested, to the Review Committee at the Delta Dental address noted previously, but you may also submit your request by standard mail. It must state specifically the reasons for requesting a review. It should contain issues, comments, and supporting materials stating why you believe the Delta Dental Vice President, Professional Relations' response was incorrect. Not later than thirty (30) days after receipt of your request, the Review Committee will render its written decision, including specific reasons for the decision.

In addition, or as an alternative to the written request procedure, you may request a hearing from the Review Committee to consider matters raised in your appeal. At the hearing, you are entitled to representation by legal counsel or other duly authorized representatives, to request the presence of a stenographer to transcribe the hearing, to present evidence, to request the testimony of witnesses and to cross-examine witnesses. You or your representative may review the policy and related pertinent documents. The hearing will be scheduled with prompt written notice to you not later than thirty (30) days after your request. A decision will be rendered not later than thirty (30) days after the hearing. The decision of the Review Committee will be in writing and will include specific reasons for the decision.

D. Notice of Right to Appeal Your Health Insurer's Final Decision

You may have a legal right to have our decision reviewed by an organization that is neutral. This is called Independent External Review. Please refer to the Agreement for more details on this process.

8. General Conditions

Assignment:

Benefits of Pediatric Members are personal and cannot be transferred.

Physical Examinations:

In consideration of waiving physical examination of you or your Dependent(s) and as a condition precedent to the approval of claims hereunder, Delta Dental shall be entitled to receive, to such extent as may be lawful and at its own expense, from any attending or examining dentist or from hospitals in which a dentist's service is rendered, such information and records relating to attendance of, or examination of, or treatment rendered to such person as may be required in the administration of such claim. At its own expense, Delta Dental shall have the right and opportunity to examine the insured when and as often as it may reasonably require while a claim for the insured is pending hereunder. However, Delta Dental shall, in every case, preserve the confidentiality of such information except as is necessary for the proper administration of Delta Dental programs.

Doctor-Patient Relationship:

The Pediatric Member has the freedom to choose any Dentist or ODP. Dentists and ODPs rendering service under this dental benefits program are independent contractors and will maintain the traditional doctor-patient relationship. The Dentist or ODP will be solely responsible to the patient for dental advice and treatment and any resulting liability.

Loss of Eligibility during Treatment:

If Pediatric Member loses eligibility while receiving dental treatment, only covered services received while eligible will be considered for payment. Someone enrolled under your policy may lose eligibility if such person ceases to be an eligible person in accordance with the provisions of the Agreement and the policies of HHS.

Maintaining Your Privacy:

Delta Dental has always respected and carefully preserved the privacy and confidentiality of Subscribers, Members, and their Dependents. As part of that protection, compliance with all state and federal laws regarding privacy of personal and health information is maintained.

For a copy of Delta Dental's Notice of Privacy Practices which describes in detail our respective privacy practices, or if you have any questions about the privacy of your health information, please contact:

Privacy Officer
Northeast Delta Dental
One Delta Drive
PO Box 2002
Concord, NH 03302-2002
1-800- 537-1715

Modification:

As referenced in this Appendix, the provisions of this Appendix are subject to the Maine Bureau and FFM requirements and modifications. Additionally, we reserve the right to implement changes in American Dental Association (ADA) dental terminology and CDT codes and Delta Dental internal processing policies which do not materially affect the provisions of this Appendix. Any material modification in this Appendix shall be valid only if approved by the Maine Bureau and MCHO.

9. Glossary

1. **Agreement:** the Member Benefit Agreement between MCHO and the Member, including all schedules, riders, applications and appendices attached thereto.
2. **DDPA (Delta Dental Plans Association):** the association which comprises all of the Delta Dental Plans and affiliated organizations operating in the United States and its territories.
3. **Denied:** if the fee for a procedure or service is Denied and chargeable to the patient, the procedure or service is not a benefit of the patient's plan. The approved amount is not payable by your plan, but is collectable from the patient.
4. **Dental Care:** services ordinarily provided by licensed Dentists for diagnosis or treatment of dental disease, injury, or abnormality based on valid dental need in accordance with generally accepted standards of dental practices at the time the service is rendered.
5. **Dentist:** a person duly licensed to practice dentistry in the state in which the Dental Care is provided.
6. **Disallowed:** if the fee for a procedure or service is Disallowed, it is not payable by your plan, nor collectable from the patient by a Participating Dentist. The Exclusions and Limitations provisions in Section 6 identify services which are Disallowed. In each instance, a Delta Dental Participating Dentist agrees not to charge a separate fee.
7. **Medically Necessary Orthodontia: "**Medically Necessary Orthodontic Services" means orthodontic services to help correct severe handicapping malocclusions caused by cranio-facial orthopedic deformities involving the teeth. Examples of conditions causing such deformities include, but are not limited to, cleft palate, Treacher-Collins syndrome, Pierre-Robin syndrome, Marfan syndrome and Crouzon syndrome. Such conditions often require a combined pre- or post-orthognathic surgery/orthodontic treatment approach.
8. **Non-Participating Dentist:** a Dentist who has not signed a Participating Agreement with Delta Dental Plan of Maine or another Delta Dental company.

9. **Other Dental Providers (ODP)**: A person, other than a Dentist, who provides Dental Care and is authorized and licensed to provide such services by the state in which the services are rendered.

10. **Participating Dentist:** a Dentist who has signed a Delta Dental Participating Agreement. A Dentist who has signed a Participating Agreement with a Delta Dental company in another state is also considered a Participating Dentist.

11. **Pediatric Member:** the Subscriber if under the age of nineteen (19) on the effective date of your plan, and any enrolled Dependent under the age of nineteen (19) on the effective date of your plan.

12. **Plan Year:** the time period commencing with enrollment through the end of the calendar year.

13. **Predetermination:** an administrative procedure by which the Dentist submits the treatment plan to Delta Dental in advance of performing Dental Care. Delta Dental recommends that you ask your Dentist to request a Predetermination of proposed services that are considered to be other than brief or routine. A Predetermination provides an estimate of what Delta Dental will pay for the services which helps avoid confusion and misunderstanding between you and your Dentist.

14. **Prior Authorization:** a required administrative procedure by which the Dentist submits a proposed treatment plan to Delta Dental in advance of performing certain specified procedures of Dental Care for approval based upon standardized and valid risk assessment tools or a Delta Dental dental consultant's review.

15. **Processing Policies:** policies approved by Delta Dental, as may be amended from time to time, to be used in processing claims for payment or review, and processing treatment plans for Prior Authorization or Predetermination. Most frequently used Processing Policies are contained in the terms, conditions, exclusions, and limitations described in this Appendix.

Northeast Delta Dental
Delta Dental Plan of New Hampshire, Inc.
One Delta Drive
PO Box 2002
Concord, NH 03302-2002

www.nedelta.com

Customer Service
603-223-1234
1-800-832-5700
TTY/Hearing Impaired
1-800-332-5905

Corporate Office
603-223-1000
1-800-537-1715
Fax: 1-800-223-1199